Commonwealth of Pennsylvania
Department of Human Services
Office of Mental Health and Substance Abuse Services

2020 External Quality Review Report
Magellan Behavioral Health

FINAL

April 2021

IPRO
Better healthcare,
realized.

Corporate Headquarters
1979 Marcus Avenue
Lake Success, NY 11042-1072
(516) 326-7767
ipro.org

Table of Contents

List of Tables and Figures

Introduction

The final rule of the Balanced Budget Act (BBA) of 1997 requires that state agencies contract with an External Quality Review Organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid Managed Care Organizations (MCOs). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that an MCO furnishes to Medicaid recipients.

OMHSAS contracted with Island Peer Review Organization (IPRO) as its EQRO to conduct the 2020 EQRs for HC BH-MCOs and to prepare the technical reports. The subject of this report is one HC BH-MCO: Magellan Behavioral Health (MBH). Subsequent references to MCO in this report refer specifically to this HC BH-MCO.

Overview

HealthChoices (HC) Behavioral Health (BH) is the mandatory managed care program which provides Medical Assistance recipients with behavioral health services in the Commonwealth of Pennsylvania (PA). The PA Department of Human Services (DHS) Office of Mental Health and Substance Abuse Services (OMHSAS) determined that the county governments would be offered the right of first opportunity to enter into capitated agreements with the Commonwealth for the administration of the HealthChoices Behavioral Health (HC BH) Program. In such cases, the Department holds the HC BH Program Standards and Requirements (PS&R) Agreement with the HC BH Contractors, referred to in this report as "Primary Contractors." Primary Contractors, in turn, subcontract with a private-sector behavioral health managed care organization (BH-MCO) to manage the HC BH Program. Forty-three (43) of the 67 counties have signed agreements using the right of first opportunity and have subcontracted with a BH-MCO. Twenty-four (24) counties have elected not to enter into a capitated agreement and, as such, the DHS/OMHSAS holds agreements directly with two BH-MCOs to directly manage the HC BH Program in those counties.

In the interest of operational efficiency, numerous counties have come together to create HealthChoices Oversight Entities that coordinate the Primary Contractors while providing an oversight function of the BH-MCOs. In some cases the HealthChoices Oversight Entity is the Primary Contractor and, in other cases, multiple Primary Contractors contract with a HealthChoices Oversight Entity to manage their HealthChoices Behavioral Health Program. In the MBH managed care network, Bucks, Cambria, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. All counties associated with MBH are individual Primary Contractors.

Objectives

The EQR-related activities that must be included in the detailed technical reports are as follows:

- review to determine plan compliance with structure and operations standards established by the State (42 CFR 438.358),
- validation of performance improvement projects, and
- validation of MCO performance measures.

Report Structure

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[1] this technical report includes seven core sections:

I. Validation of Performance Improvement Projects
II. Validation of Performance Measures
III. Review of Compliance with Medicaid Managed Care Regulations
IV. Quality Studies
V. 2019 Opportunities for Improvement – MCO Response
VI. 2020 Strengths and Opportunities for Improvement
VII. Summary of Activities

For the MCO, Information for Sections II and III of this report is derived from IPRO's validation of the MCO's performance improvement projects (PIPs) and performance measure (PM) submissions. The PM validation, as conducted by IPRO, included a repeated measurement of two PMs: Follow-up After Hospitalization for Mental Illness, and Readmission Within 30 Days of Inpatient Psychiatric Discharge. The information for compliance with Medicaid Managed Care Regulations in section III of the report is derived from monitoring and reviews conducted by OMHSAS, as well as the

oversight functions of the county or contracted entity, when applicable, against the Commonwealth's Program Evaluation Performance Summary (PEPS) Review Application and/or Readiness Assessment Instrument (RAI), as applicable. Section IV discusses the Quality Study for the Certified Community Behavioral Health Clinic federal demonstration and the integrated Community Wellness Centers program. Section V, 2019 Opportunities for Improvement – MCO Response, includes the MCO's responses to opportunities for improvement noted in the 2019 (MY 2018) EQR Technical Report and presents the degree to which the MCO addressed each opportunity for improvement. Section VI includes a summary of the MCO's strengths and opportunities for improvement for this review period (MY 2019), as determined by IPRO, and a "report card" of the MCO's performance as related to the quality indicators (QIs) included in the EQR evaluation for HC BH Quality Performance of the MCO. Lastly, Section VII provides a summary of EQR activities for the MCO for this review period, an appendix that includes crosswalks of PEPS standards to pertinent BBA regulations and to OMHSAS-specific PEPS Substandards, as well as results of the PEPS review for OMHSAS-specific standards, followed by a list of literature references cited in this report.

Supplemental Materials

Upon request, the following supplemental materials can be made available:

- the MCO's BBA Report for MY 2019, and
- All attachments or embedded objects within MCO Responses to Opportunities for Improvement (as identified in the MCO's 2019 BBA Report).

I: Validation of Performance Improvement Projects

In accordance with current BBA regulations, IPRO validates at least one performance improvement project (PIP) for the MCO. Under the existing HC BH agreement with OMHSAS, Primary Contractors, along with the responsible subcontracted entities (i.e., MCOs), are required to conduct a minimum of two focused studies per year. The Primary Contractors and MCOs are required to implement improvement actions and to conduct follow-up, including, but not limited to, subsequent studies or remeasurement of previous studies in order to demonstrate improvement or the need for further action.

Background

CY 2019 saw the winding down of one PIP project and the formation of a new project. MCOs submitted their final reports for the EQR PIP topic "Successful Transitions from Inpatient Care to Ambulatory Care for Pennsylvania HealthChoices Members Hospitalized with a Mental Health or a Substance Abuse Diagnosis." The results of IPRO's validation of the complete project were reported in the 2019 BBA reports.

In 2019, OMHSAS directed IPRO to complete a preliminary study of substance use disorders (SUD) in the Commonwealth preliminary to selection of a new PIP topic. As a result, OMHSAS selected the topic, "Successful Prevention, Early Detection, Treatment, and Recovery (SPEDTAR) for Substance Use Disorders" as a PIP for all BH-MCOs in the State. The PIP will extend from 2021 through 2023, including a final report due in 2024. While the topic will be common to Primary Contractors and BH-MCOs, each project will be developed as a collaboration and discussion between Primary Contractors and their contracted BH-MCOs. Primary Contractors and BH-MCOs were directed to begin conducting independent analyses of their data and partnering to develop relevant PMs and interventions. BH-MCOs will be responsible for coordinating, implementing, and reporting the project.

The Aim Statement for this PIP, reflecting an emphasis on reducing racial and ethnic health disparities, is: "Significantly slow (and eventually stop) the growth of SUD prevalence among HC members while improving outcomes for those individuals with SUD, and also addressing racial and ethnic health disparities through a systematic and person-centered approach."

OMHSAS selected three common (for all MCOs) clinical objectives and one non-clinical population health objective:

1. Increase access to appropriate screening, referral, and treatment for members with an Opioid and/or other SUD;
2. Improve retention in treatment for members with an Opioid and/or other SUD diagnosis;
3. Increase concurrent use of Drug & Alcohol counseling in conjunction with Pharmacotherapy (Medication-Assisted Treatment); and
4. Develop a population-based prevention strategy with a minimum of at least two activities across the MCO/HC BH Contracting networks. The two "activities" may fall under a single intervention or may compose two distinct interventions. Note that while the emphasis here is on population-based strategies, this non-clinical objective should be interpreted within the PIP lens to potentially include interventions that target or collaborate with providers and health care systems in support of a specific population (SUD) health objective.

Additionally, OMHSAS identified the following core PMs for the SPEDTAR PIP:

1. **Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)** – This Healthcare Effectiveness Data and Information Set (HEDIS®) measure measures "the percentage of acute inpatient hospitalizations, residential treatment or detoxification visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder."[2] It contains two submeasures: continuity of care within 7 days, and continuity of care within 30 days of the index discharge or visit.
2. **Substance Use Disorder-Related Avoidable Readmissions (SAR) –** This is a PA-specific measure that measures avoidable readmissions for HC members 13 years of age and older discharged from detox, inpatient rehab, or residential services with an alcohol and other drug dependence (AOD) primary diagnosis. The measure proposes to require 30 days of continuous enrollment (from the index discharge date) in the plan's HC program. The measure will measure discharges, not individuals (starting from Day 1 of the MY, if multiple qualifying discharges within any 30-day period, only the earliest discharge is counted in the denominator). The SUD avoidable readmissions submeasure is intended here to complement FUI and recognizes that appropriate levels of care for individuals with

SUD will depend on the particular circumstances and conditions of the individual. Therefore, for this submeasure, "avoidable readmission" will include detox episodes only.

3. **Mental Health-Related Avoidable Readmissions (MHR) –** This PA-specific measure will use the same denominator as SAR. The measure recognizes the high comorbidity rates of MH conditions among SUD members and is designed to assess screening, detection, early intervention, and treatment for MH conditions before they reach a critical stage. For this measure, "readmission" will be defined as any acute inpatient admission with a primary MH diagnosis, as defined by the PA-specific FUH measure, occurring within 30 days of a qualifying discharge from AOD detox, inpatient rehab, or residential services.
4. **Medication-Assisted Treatment for Opioid Use Disorder (MAT-OUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of opioid use disorder (OUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their OUD during the measurement period. This PA-specific measure is based on a CMS measure of "the percentage of Medicaid beneficiaries ages 18–64 with an OUD who filled a prescription for or were administered or dispensed an FDA-approved medication for the disorder during the measure year."[3] This measure will be adapted to include members age 16 years and older. BH counseling is not necessarily limited to addiction counseling.
5. **Medication-Assisted Treatment for Alcohol Use Disorder (MAT-AUD) –** This PA-specific performance indicator measures the percentage of HC BH beneficiaries with an active diagnosis of moderate to severe Alcohol Use Disorder (AUD) in the measurement period who received both BH counseling services as well as pharmacotherapy for their AUD during the measurement period. This PA-specific measure mirrors the logic of MAT-OUD, except for members age 16 years and older with severe or moderate AUD. BH counseling is not necessarily limited to addiction counseling.

MCOs are expected to submit results to IPRO on an annual basis. In addition to running as annual measures, quarterly rates will be used to enable measurement on a frequency that will support continuous monitoring and adjustment by the MCOs and their Primary Contractors.

This PIP project will extend from January 2021 through December 2023, with initial PIP proposals submitted in 2020 and a final report due in September 2024. Final baseline results will be run for the performance indicators in Summer 2021 and PIP interventions recalibrated as needed.

This report marks the 17th EQR review to include validation of PIPs. With this PIP cycle, all MCOs/Primary Contractors share the same baseline period and timeline.

The MCOs are required by OMHSAS to submit their projects using a standardized PIP template form, which is consistent with CMS protocols. These protocols follow a longitudinal format and capture information relating to:

- Project Topic
- Methodology
- Barrier Analysis, Interventions, and Monitoring
- Results
- Discussion

For the SPEDTAR PIP, OMHSAS has designated the Primary Contractors to conduct quarterly PIP review calls with each MCO. The purpose of these calls will be to discuss ongoing monitoring of PIP activity, to discuss the status of implementing planned interventions, and to provide a forum for ongoing technical assistance, as necessary. Plans will be asked to provide up-to-date data on process measures and outcome measures prior to each meeting. Because of the level of detail provided during these meetings, rather than two semiannual submissions, MCOs will submit only one PIP interim report each September starting in 2021.

Validation Methodology

IPRO's validation of PIP activities is consistent with the protocol issued by CMS[4] and meets the requirements of the Final Rule on the EQR of Medicaid MCOs. IPRO's review evaluates each project for compliance with the 8 review elements listed below:

1. Topic Rationale
2. Aim
3. Methodology
4. Identified Study Population Barrier Analysis
5. Robust Interventions
6. Results
7. Discussion and Validity of Reported Improvement
8. Sustainability

The first seven elements relate to the baseline and demonstrable improvement phases of the project. The last element relates to sustaining improvement from the baseline measurement. Each element carries a separate weight. Scoring for each element is based on full, partial, and non-compliance.

II: Validation of Performance Measures

In 2019, OMHSAS and IPRO conducted two EQR studies. Both the Follow-Up After Hospitalization for Mental Illness (FUH) and Readmission Within 30 Days of Inpatient Psychiatric Discharge studies were remeasured in 2019.

Follow-Up After Hospitalization for Mental Illness

This PM assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge. The measure continues to be of interest to OMHSAS for the purpose of comparing county, Primary Contractor, and BH-MCO rates to available national benchmarks and to prior years' rates.

Measurement year (MY) 2002 was the first year follow-up rates were reported. Quality Indicator (QI) 1 and QI 2 utilize the HEDIS methodology for this measure. The PA-specific indicators were added to include services with high utilization in the HC BH Program that could not be mapped to any of the standard coding used in the HEDIS measure to identify follow-up office visits. Each year, the QI 1 and QI 2 specifications are aligned with the HEDIS Follow-Up After Mental Health Hospitalization measure. The PA-specific codes that are not included in the HEDIS measure are also reviewed for accuracy on an annual basis.

Typically, HEDIS FUH undergoes annual updates to its specifications. Among the updates in 2019 (MY 2018), the National Committee for Quality Assurance (NCQA) added the following reporting strata for FUH, ages: 6–17, 18–64, and 65 and over. These changes resulted in a change in the reporting of FUH results in this report, which are broken out by ages: 6–17, 18–64, and 6 and over (All Ages).

Measure Selection and Description

In accordance with DHS guidelines, IPRO created the indicator specifications to resemble HEDIS specifications. For each indicator, the criteria specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. To identify the administrative numerator positives, date of service and diagnosis/procedure code criteria were outlined, as well as other specifications as needed. Indicator rates were calculated using only the BH-MCO's data systems to identify numerator positives (i.e., administratively).

This PM assessed the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders, who were seen on an ambulatory basis, or who were in day/night treatment with a mental health provider on the date of discharge up to 7 and 30 days after hospital discharge.

There were four separate measurements related to Follow-Up After Hospitalization. All utilized the same denominator but had different numerators.

Eligible Population

The entire eligible population was used for all 25 Primary Contractors participating in the MY 2019 study. Eligible cases were defined as those members in the HC BH program who met the following criteria:

- Members who had one (or more) hospital discharges from any acute care facility with a discharge date occurring between January 1 and December 1, 2019;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Six (6) years old and over as of the date of discharge; and
- Continuously enrolled from the date of hospital discharge through 30 days after discharge, with no gaps in enrollment.

Members with multiple discharges on or before December 1, 2019, greater than 30 days apart, with a principal diagnosis indicating one of the mental health disorders specified are counted more than once in the eligible population. If a readmission or direct transfer followed a discharge for one of the selected mental health disorders to an acute mental health facility within 30 days after discharge, only the subsequent discharge is counted in the denominator, as long as the subsequent discharge is on or before December 1, 2019. The methodology for identification of the eligible population for these indicators was consistent with the HEDIS MY 2019 methodology for the Follow-Up After Hospitalization for Mental Illness measure.

HEDIS Follow-Up Indicators

Quality Indicator 1 (QI 1): Follow-Up After Hospitalization for Mental Illness Within 7 Days After Discharge (calculation based on industry standard codes used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner on the date of discharge up to 7 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator 2 (QI 2): Follow-Up After Hospitalization for Mental Illness Within 30 Days After Discharge (calculation based on industry standard codes used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard ambulatory service codes. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

PA-Specific Follow-Up Indicators

Quality Indicator A (QI A): Follow-up After Hospitalization for Mental Illness Within 7 Days After Discharge (calculation based on numerator 1 codes and additional PA-specific codes not used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 7 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator B (QI B): Follow-up After Hospitalization for Mental Illness Within 30 Days after Discharge (calculation based on numerator 1 codes and additional PA-specific codes not used in HEDIS)

Numerator: An ambulatory visit with a mental health practitioner or peer support network on the date of discharge or up to 30 days after hospital discharge with one of the qualifying industry standard or one of the PA-specific ambulatory service codes provided. The date of service must clearly indicate a qualifying ambulatory visit with a mental health practitioner or day/night treatment with a mental health practitioner.

Quality Indicator Significance

Mental disorders also contribute to excess mortality from suicide, one of the leading preventable causes of death in the United States. In 2018, an estimated 47.6 million adults aged 18 or older (19.1%) had any mental illness in the past year while an estimated 11.4 million adults in the nation had serious mental illness in the past year, which corresponds to 4.6% of all U.S. adults.[5] Additionally, patients with schizophrenia or bipolar disorder have elevated rates of preventable medical co-morbidities such as obesity, cardiovascular diseases, and diabetes, partly attributed to the epidemiology of the disorder, antipsychotic prescription patterns, reduced use of preventive services, and substandard medical care that they receive.[6] Around one-third of adults with serious mental illness (SMI) in any given year did not receive any mental health services, showing a disparity among those with SMI.[7] Further research suggests that more than half of those with SMI did not receive services because they could not afford the cost of care.[8] Cost of care broke down as follows: 60.8% of patients' related expenses were attributed to loss of earnings, 31.5% were attributed to healthcare expenses, while 7.7% were attributed to payments for disability benefits.[9] For these reasons, timely and appropriate treatment for mental illnesses is essential.

It has long been recognized that continuity of care is critical to positive outcome and to prevent long-term deterioration in people with severe and persistent mental illness.[10] As noted in *The State of Health Care Quality Report,*[11] appropriate treatment and follow-up care can reduce the duration of disability from mental illnesses and the likelihood of recurrence. An outpatient visit within at least 30 days (ideally, 7 days) of discharge ensures that the patient's transition to home and/or work is supported and that gains made during hospitalization are maintained. These types of contacts specifically allow physicians to ensure medication effectiveness and compliance and to identify complications early on in order to avoid more inappropriate and costly use of hospitals and emergency departments.[12] With the expansion of evidence-based practice in the recent decade, continuity has become a core principle in care delivery and in performance measurement for mental health services.[13] One way to improve continuity of care is to provide greater

readiness of aftercare by shortening the time between discharge from the hospital and the first day of outpatient contact.[14]

The difficulty in engaging psychiatric patients after inpatient hospitalization, however, has been a long-standing concern of behavioral health care systems, with some researchers having estimated that 40–60% of patients fail to connect with an outpatient clinician.[15] Research has demonstrated that patients who do not have an outpatient appointment after discharge were more likely to be re-hospitalized in the same year than patients who kept at least one outpatient appointment.[16] Over the course of a year, patients who have kept appointments have been shown to have a decreased chance of being re-hospitalized than those who do not follow up with outpatient care.[17]

There are various measures of treatment efficacy, such as service satisfaction, functional status, and health outcomes. Among them, rehospitalization rates continue to be used as a reliable indicator of the effectiveness of inpatient treatment.[18] Inpatient readmission is clearly a step backward in treatment and a costly alternative to effective and efficient ambulatory care. Timely follow-up care, therefore, is an important component of comprehensive care and is an effective means to control the cost and maximize the quality of mental health services. Additionally, mental illness continues to impact the PA population, including those with substance abuse concerns or substance use disorder (SUD).[19] Measuring appropriate care transitions for members with mental illness therefore carries wider implications for the OMHSAS quality area related to SUD prevalence and outcomes.

As noted, timely follow-up after hospitalization for mental illness has been and remains a focus for OMHSAS and results are reviewed for potential trends each year. While factors such as those outlined in this section may persist and continue to impact follow-up rates, OMHSAS is exploring new and related areas of research as well as the factors that may impact optimal follow-up. OMHSAS will continue to discuss the development of new or enhanced initiatives with the goal of continual improvement of care.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs for each Primary Contractor participating in the current study. The source for all administrative data was the BH-MCOs' transactional claims systems. Each BH-MCO was also required to submit the follow-up rates calculated for the four indicators, along with their data files for validation purposes. The BH-MCOs were given the opportunity for resubmission, as necessary.

Performance Goals

At the conclusion of the validation process for MY 2011, OMHSAS began re-examination of the benchmarks. This discussion was based on several years of performance data from this measure, as well as the comparisons to the HEDIS percentiles. As a result of this discussion, OMHSAS adopted HEDIS percentiles as the goals for the HEDIS follow-up indicators. In 2019 (MY 2018), in part to better account for the growing population of members 65 years old and older, OMHSAS changed its benchmarking to the FUH All Ages (6+ years old) measure. OMHSAS established a 3-year goal for the State to meet or exceed the 75th percentile for the All Ages measure, based on the annual HEDIS Quality Compass® published percentiles for 7-day and 30-day FUH. This change in 2019 also coincided with a more proactive approach to goal-setting. BH-MCOs were given interim goals for MY 2019 for both the 7-day and 30-day FUH All Ages rates based on their MY 2018 results. These MY 2018 results were reported in the 2019 BBA report.

HEDIS percentiles for the 7-day and 30-day FUH All-Ages indicators have been adopted as the benchmarks for determining the requirement for a root cause analysis (RCA) and corresponding quality improvement plan (QIP) for each underperforming indicator. Rates for the HEDIS FUH 7-day and 30-day indicators that fall below the 75th percentile for each of these respective indicators will result in a request to the BH-MCO for an RCA and QIP. This process is further discussed in **Section V**.

Although not part of this report, OMHSAS sponsored in 2019 the rollout of an IPRO-hosted Tableau® server reporting platform, which allows users, including BH-MCOs and Primary Contractors, to interactively query data and produce reports on PMs. These reports include statistical or non-statistical summaries and comparisons of rates by various stratifications, including by demographics, such as race and ethnicity, as well as by participation status in the Medicaid Expansion program (Pennsylvania continued its Medicaid expansion under the Affordable Care Act in 2019). This

interactive reporting provides an important tool for BH-MCOs and their HC Oversight Entities to set performance goals as well as monitor progress toward those goals.

Data Analysis

The quality indicators were defined as rates, based on a numerator of qualifying events or members and a denominator of qualifying events or members, defined according to the specifications of the measure. The HC Aggregate (Statewide) for each indicator was the total numerator divided by the total denominator, which represented the rate derived for the Statewide population of denominator-qualifying events or members. Year-to-year comparisons to MY 2018 rates were provided where applicable. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. To compare rates, a *z* statistic for comparing proportions for two independent samples was used. To calculate the test statistic, the two proportions were averaged ("pooled") through the following formula:

$$\hat{p} = \frac{\mathrm{N1} + \mathrm{N2}}{\mathrm{D1} + \mathrm{D2}}$$

Where:

*N*1 = Current year (MY 2019) numerator,
*N*2 = Prior year (MY 2018) numerator,
*D*1 = Current year (MY 2019) denominator, and
*D*2 = Prior year (MY 2018) denominator.

The single proportion estimate was then used for estimating the standard error (SE).
Z-test statistic was obtained by dividing the difference between the proportions by the standard error of the difference. Analysis that uses the *Z* test assumes that the data and their test statistics approximate a normal distribution. To correct for approximation error, the Yates correction for continuity was applied:

$$z - statistic = \frac{ABS(p1 - p2) - 0.5(\frac{1}{D1} + \frac{1}{D2})}{\sqrt{\hat{p}(1 - \hat{p})[\frac{1}{D1} + \frac{1}{D2}]}}$$

Where:

*p*1 = Current year (MY 2019) quality indicator rate, and
*p*2 = Prior year (MY 2018) quality indicator rate.

Two-tailed statistical significance tests were conducted at $p = 0.05$ to test the null hypothesis of:

$$H_0: p1 = p2$$

Percentage point difference (PPD) as well as 95% confidence intervals for difference between the two proportions were also calculated. Confidence intervals were not calculated if denominators of rates contained fewer than 100 members.

Limitations

The tables and figures in this section present rates, confidence intervals, and tests of statistical significance for Primary Contractors. Caution should be exercised when interpreting results for small denominators. A denominator of 100 or greater is preferred for drawing conclusions from *z*-score tests of the PM results. In addition, the above analysis assumes that the proportions being compared come from independent samples. To the extent that this is not the case, the findings should be interpreted with caution.

Findings

BH-MCO and Primary Contractor Results

The HEDIS follow-up indicators are presented for three age groups: ages 18 to 64, ages 6 and older, and ages 6 to 17. The 6+ years old ("All Ages") results are presented to show the follow-up rates for the overall HEDIS population, and the 6 to 17 years old age group results are presented to support the Children's Health Insurance Program Reauthorization

Act (CHIPRA) reporting requirements. The results for the PA-specific follow-up indicators are presented for ages 6+ years old only.

The results are presented at the BH-MCO and Primary Contractor level. The BH-MCO-specific rates were calculated using the numerator (N) and denominator (D) for that particular BH-MCO (and Primary Contractor with the same contracted BH-MCO). The Primary Contractor-specific rates were calculated using the numerators and denominators for that particular Primary Contractor. For each of these rates, the 95% confidence interval (CI) is reported. The HC BH Aggregate (Statewide) rates were also calculated for the indicators.

BH-MCO-specific rates were compared to the HC BH Statewide rates to determine if they were statistically significantly above or below that value. Statistically significant BH-MCO differences are noted. Primary Contractor-specific rates were also compared to the HC BH Statewide rates to determine if they were statistically significantly above or below that value Statistically significant Primary Contractor-specific differences are noted.

The HEDIS follow-up results for the 6+ years old age groups are compared to the HEDIS 2019 national percentiles to show BH-MCO and Primary Contractor progress with meeting the OMHSAS goal of follow-up rates at or above the 75th percentile. The HEDIS follow-up results for the 6 to 17 years old age group and 18 to 64 years old age group are not compared to HEDIS benchmarks.

I: HEDIS Follow-Up Indicators

(a) Age Group: 18–64 Years Old

Table 2.1 shows the MY 2019 results for both the HEDIS 7-day and 30-day follow-up measures for members 18 to 64 years old compared to MY 2018.

Table 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (18–64 Years)

	MY 2019						MY 2019 Rate Comparison to MY 2018	
				95% CI		MY 2018		
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI 1 – HEDIS 7-Day Follow-Up (18–64 Years)								
HC BH (Statewide)	10,935	30,472	**35.9%**	35.3%	36.4%	35.5%	0.4	NO
Magellan	1,948	5,451	**35.7%**	34.5%	37.0%	34.9%	0.8	NO
Bucks	327	853	**38.3%**	35.0%	41.7%	34.5%	3.9	NO
Cambria	128	437	**29.3%**	24.9%	33.7%	31.9%	-2.6	NO
Delaware	338	1,010	**33.5%**	30.5%	36.4%	30.7%	2.7	NO
Lehigh	446	1,222	**36.5%**	33.8%	39.2%	37.5%	-1.0	NO
Montgomery	468	1,227	**38.1%**	35.4%	40.9%	37.4%	0.7	NO
Northampton	241	702	**34.3%**	30.7%	37.9%	34.9%	-0.6	NO
QI 2 – HEDIS 30-Day Follow-Up (18–64 Years)								
HC BH (Statewide)	16,997	30,472	**55.8%**	55.2%	56.3%	56.0%	-0.3	NO
Magellan	3,166	5,451	**58.1%**	56.8%	59.4%	57.5%	0.6	NO
Bucks	483	853	**56.6%**	53.2%	60.0%	56.4%	0.2	NO
Cambria	283	437	**64.8%**	60.2%	69.4%	57.9%	6.9	YES
Delaware	519	1,010	**51.4%**	48.3%	54.5%	49.8%	1.5	NO
Lehigh	734	1,222	**60.1%**	57.3%	62.9%	60.8%	-0.8	NO
Montgomery	722	1,227	**58.8%**	56.0%	61.6%	59.9%	-1.1	NO
Northampton	425	702	**60.5%**	56.9%	64.2%	59.7%	0.8	NO

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

Figure 2.1 is a graphical representation of MY 2019 HEDIS FUH 7- and 30-Day follow-up rates in the 18 to 64 years old population for MBH and its associated Primary Contractors. The orange line indicates the MCO average.

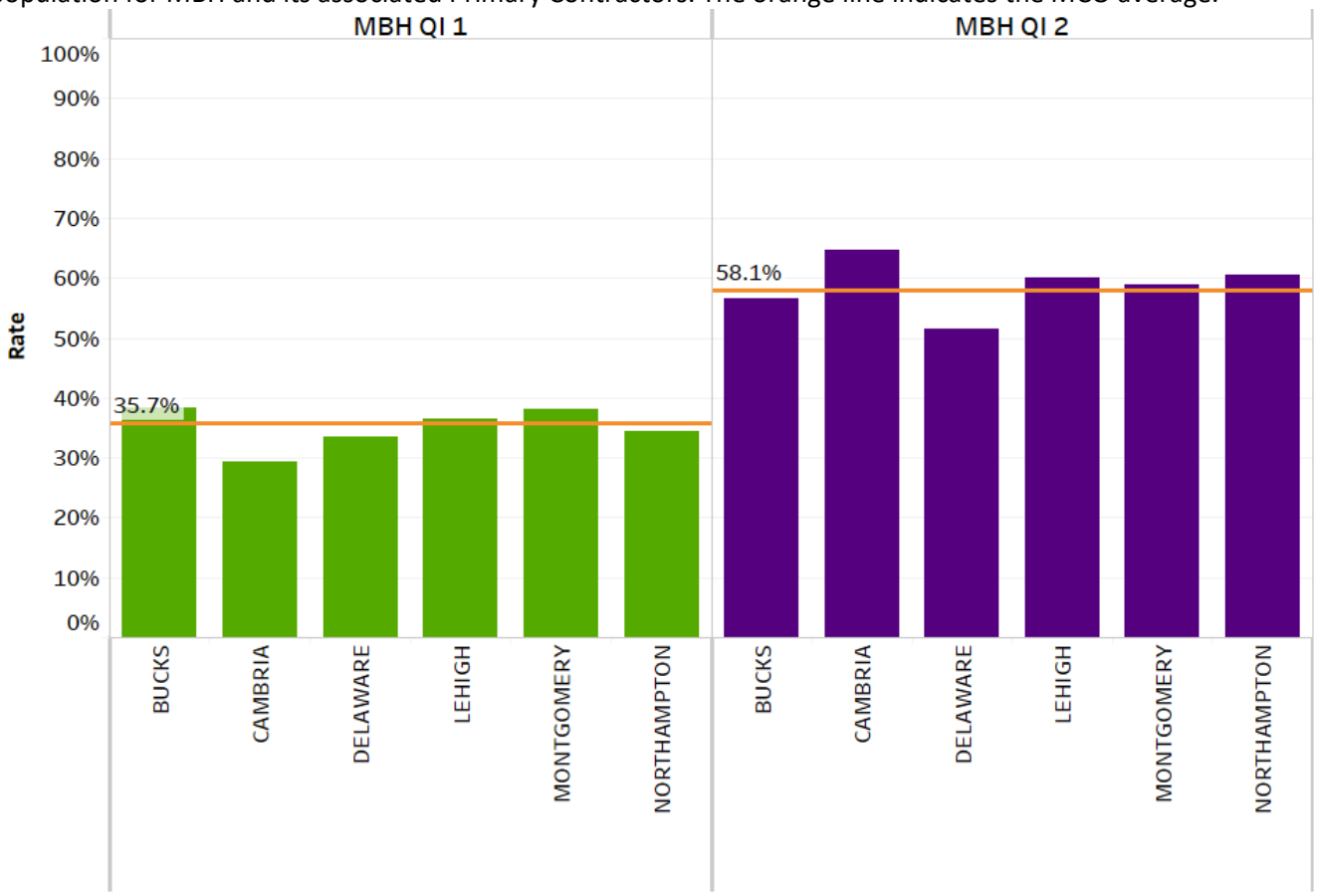

Figure 2.1: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years).

Figure 2.2 shows the HC BH (Statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the HC BH (Statewide) rate.

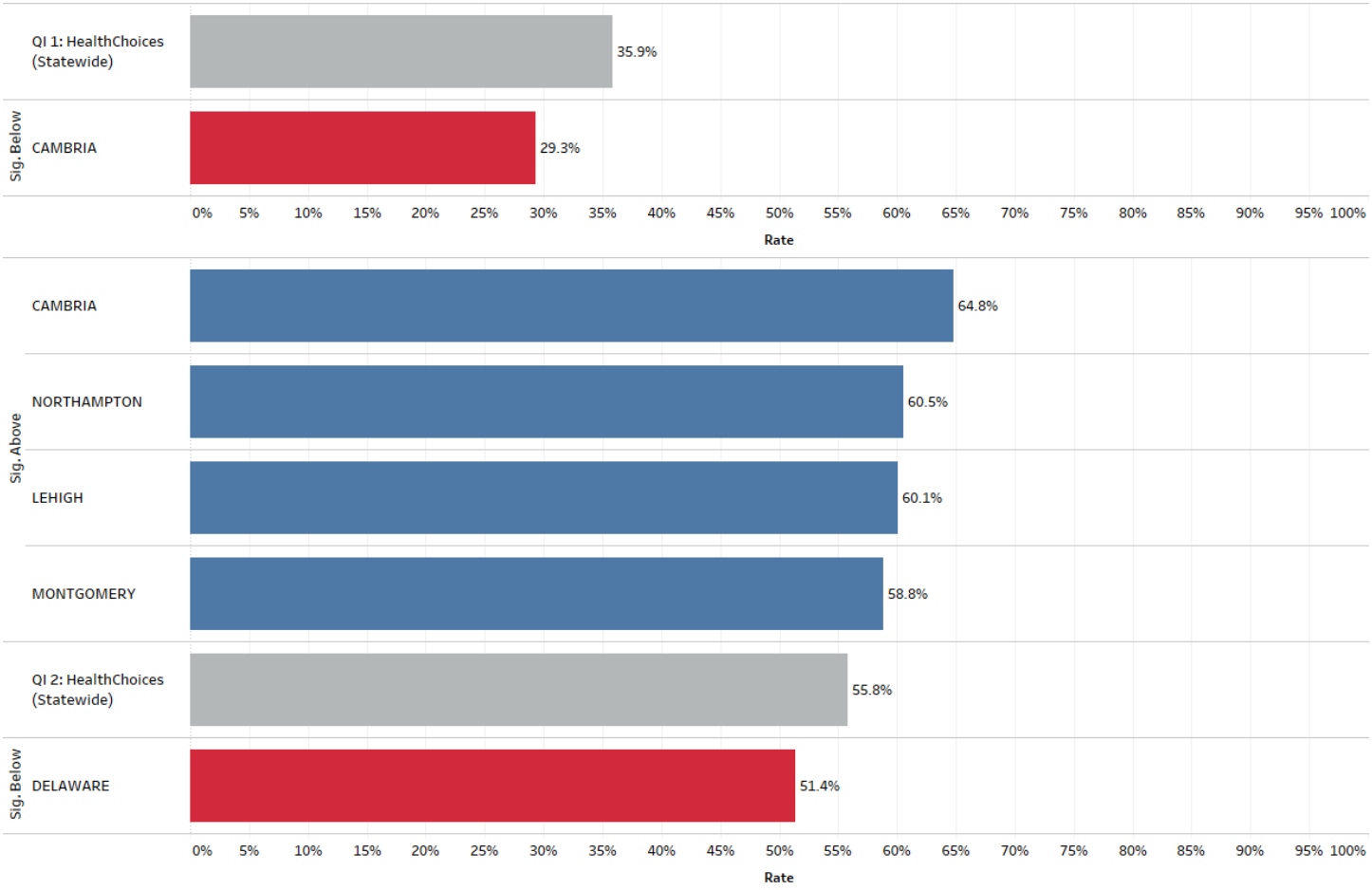

Figure 2.2: MBH Contractor MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (18–64 Years) that are Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (18–64 Years).

(b) Overall Population: 6+ Years Old

The MY 2019 HC Aggregate HEDIS and MBH are shown in **Table 2.2**.

Table 2.2: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (All Ages)

MY 2019							MY 2019 Rate Comparison		
				95% CI		MY 2018	To MY 2018		To HEDIS 2019
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD	Percentiles
QI 1 – HEDIS 7-Day Follow-up (All Ages)									
HC BH (Statewide)	15,843	39,823	**39.8%**	39.3%	40.3%	39.4%	0.4	NO	Below 75th percentile, above 50th percentile
Magellan	2,720	7,081	**38.4%**	37.3%	39.6%	37.3%	1.1	NO	Below 75th percentile, above 50th percentile
Bucks	465	1,147	**40.5%**	37.7%	43.4%	37.1%	3.5	NO	Below 75th percentile, above 50th percentile
Cambria	177	559	**31.7%**	27.7%	35.6%	33.1%	-1.4	NO	Below 50th percentile, above 25th percentile
Delaware	476	1,289	**36.9%**	34.3%	39.6%	34.7%	2.2	NO	Below 75th percentile, above 50th percentile
Lehigh	584	1,549	**37.7%**	35.3%	40.1%	39.4%	-1.7	NO	Below 75th percentile, above 50th percentile
Montgomery	671	1,613	**41.6%**	39.2%	44.0%	39.8%	1.8	NO	Below 75th percentile, above 50th percentile
Northampton	347	924	**37.6%**	34.4%	40.7%	36.3%	1.2	NO	Below 75th percentile, above 50th percentile

MY 2019							MY 2019 Rate Comparison		
				95% CI		MY 2018	To MY 2018		To HEDIS 2019
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD	Percentiles
QI 2 – HEDIS 30-Day Follow-Up (All Ages)									
HC BH (Statewide)	24,029	39,823	60.3%	59.9%	60.8%	60.2%	0.2	NO	Below 75th percentile, above 50th percentile
Magellan	4,348	7,081	61.4%	60.3%	62.5%	60.3%	1.1	NO	Below 75th percentile, above 50th percentile
Bucks	696	1,147	60.7%	57.8%	63.6%	60.1%	0.5	NO	Below 75th percentile, above 50th percentile
Cambria	371	559	66.4%	62.4%	70.4%	60.3%	6.0	YES	Below 75th percentile, above 50th percentile
Delaware	717	1,289	55.6%	52.9%	58.4%	53.8%	1.8	NO	Below 50th percentile, above 25th percentile
Lehigh	966	1,549	62.4%	59.9%	64.8%	62.9%	-0.5	NO	Below 75th percentile, above 50th percentile
Montgomery	1,006	1,613	62.4%	60.0%	64.8%	62.5%	-0.1	NO	Below 75th percentile, above 50th percentile
Northampton	592	924	64.1%	60.9%	67.2%	61.4%	2.6	NO	Below 75th percentile, above 50th percentile

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference; QI: quality indicator.

Figure 2.3 is a graphical representation of the MY 2019 HEDIS follow-up rates for MBH and its associated Primary Contractors. The orange line indicates the MCO average.

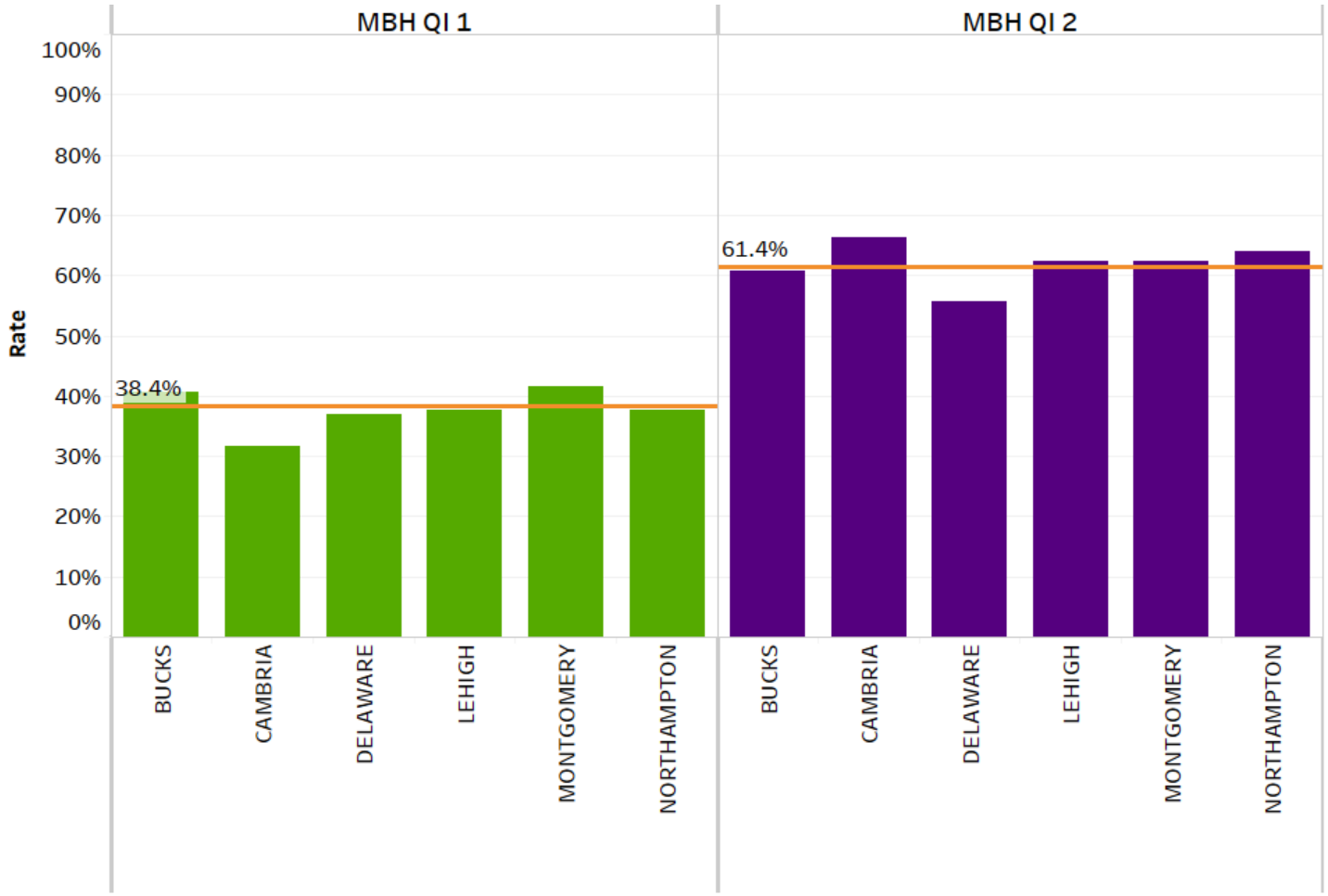

Figure 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (All Ages).

Figure 2.4 shows the HC BH (Statewide) rates and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than its statewide benchmark.

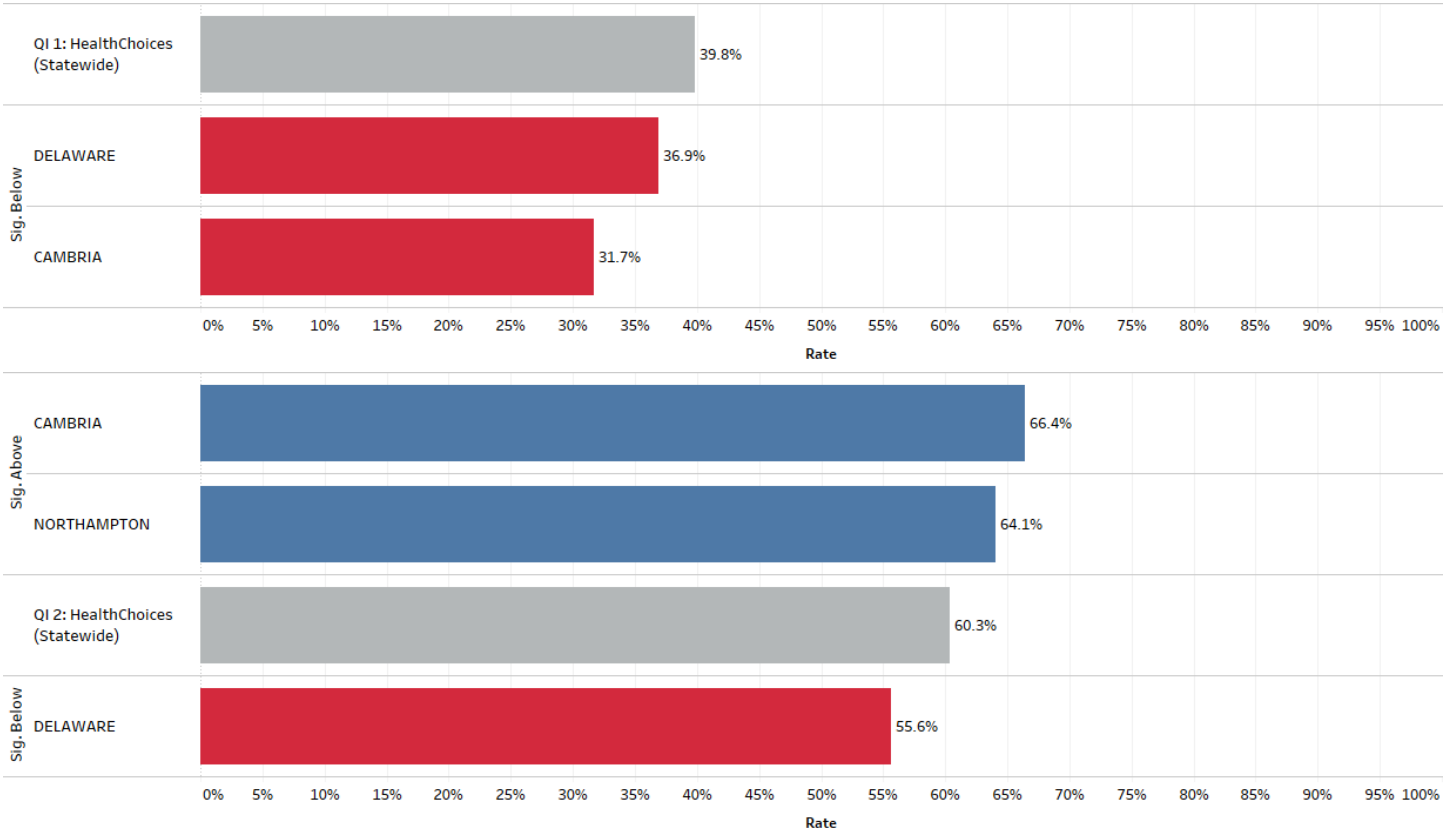

Figure 2.4: MBH Contractor MY 2019 HEDIS FUH 7- and 30-Day Follow-up Rates (All Ages) that are Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-up Rates (All Ages).

(c) Age Group: 6–17 Years Old

Table 2.3 shows the MY 2019 results for both the HEDIS 7-day and 30-day follow-up measures for members aged 6–17 years compared to MY 2018.

Table 2.3: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Indicators (6–17 Years)

	MY 2019					MY 2018	MY 2019 Rate Comparison to MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI 1 - HEDIS 7-Day Follow-Up (6–17 Years)								
HC BH (Statewide)	4,750	8,573	**55.4%**	54.3%	56.5%	55.7%	-0.3	NO
Magellan	753	1,525	**49.4%**	46.8%	51.9%	47.6%	1.8	NO
Bucks	133	276	**48.2%**	42.1%	54.3%	47.9%	0.3	NO
Cambria	49	112	**43.8%**	34.1%	53.4%	41.3%	2.4	NO
Delaware	135	263	**51.3%**	45.1%	57.6%	51.0%	0.3	NO
Lehigh	131	302	**43.4%**	37.6%	49.1%	48.2%	-4.8	NO
Montgomery	200	360	**55.6%**	50.3%	60.8%	51.8%	3.7	NO
Northampton	105	212	**49.5%**	42.6%	56.5%	40.7%	8.8	NO
QI 2 - HEDIS 30-Day Follow-Up (6–17 Years)								
HC BH (Statewide)	6,756	8,573	**78.8%**	77.9%	79.7%	77.7%	1.1	NO
Magellan	1,140	1,525	**74.8%**	72.5%	77.0%	71.6%	3.2	NO
Bucks	203	276	**73.6%**	68.2%	78.9%	74.8%	-1.2	NO
Cambria	86	112	**76.8%**	68.5%	85.1%	76.0%	0.8	NO
Delaware	192	263	**73.0%**	67.4%	78.6%	70.0%	3.0	NO
Lehigh	221	302	**73.2%**	68.0%	78.3%	72.3%	0.9	NO
Montgomery	274	360	**76.1%**	71.6%	80.7%	72.9%	3.2	NO
Northampton	164	212	**77.4%**	71.5%	83.2%	66.0%	11.4	YES

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-Up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

Figure 2.5 is a graphical representation of the MY 2019 HEDIS FUH 7- and 30-Day follow-up rates in the 6 to 17 years old population for MBH and its associated Primary Contractors. The orange line indicates the MCO average.

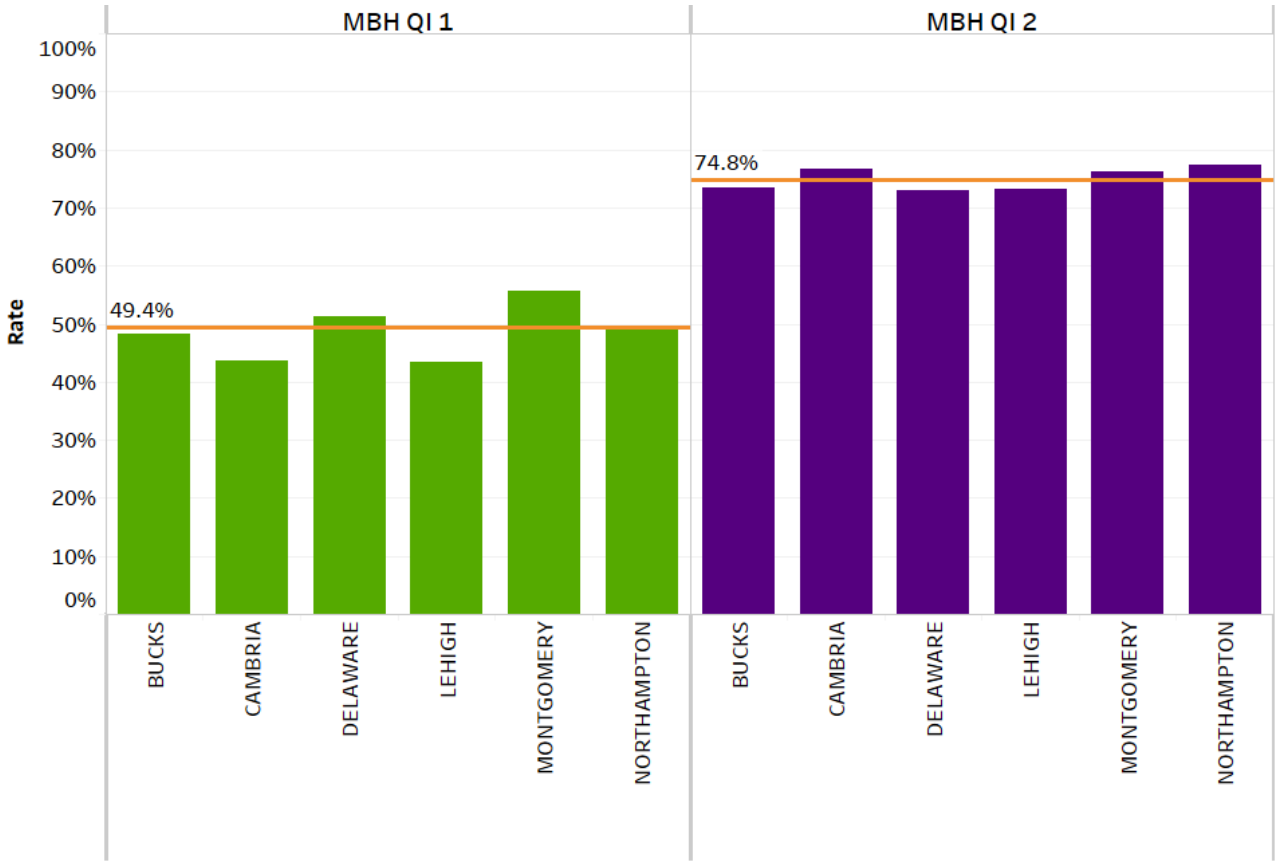

Figure 2.5: MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years).

Figure 2.6 shows the HC BH (Statewide) rates for this age cohort and the individual Primary Contractor rates that were statistically significantly higher (blue) or lower (red) than the statewide rates.

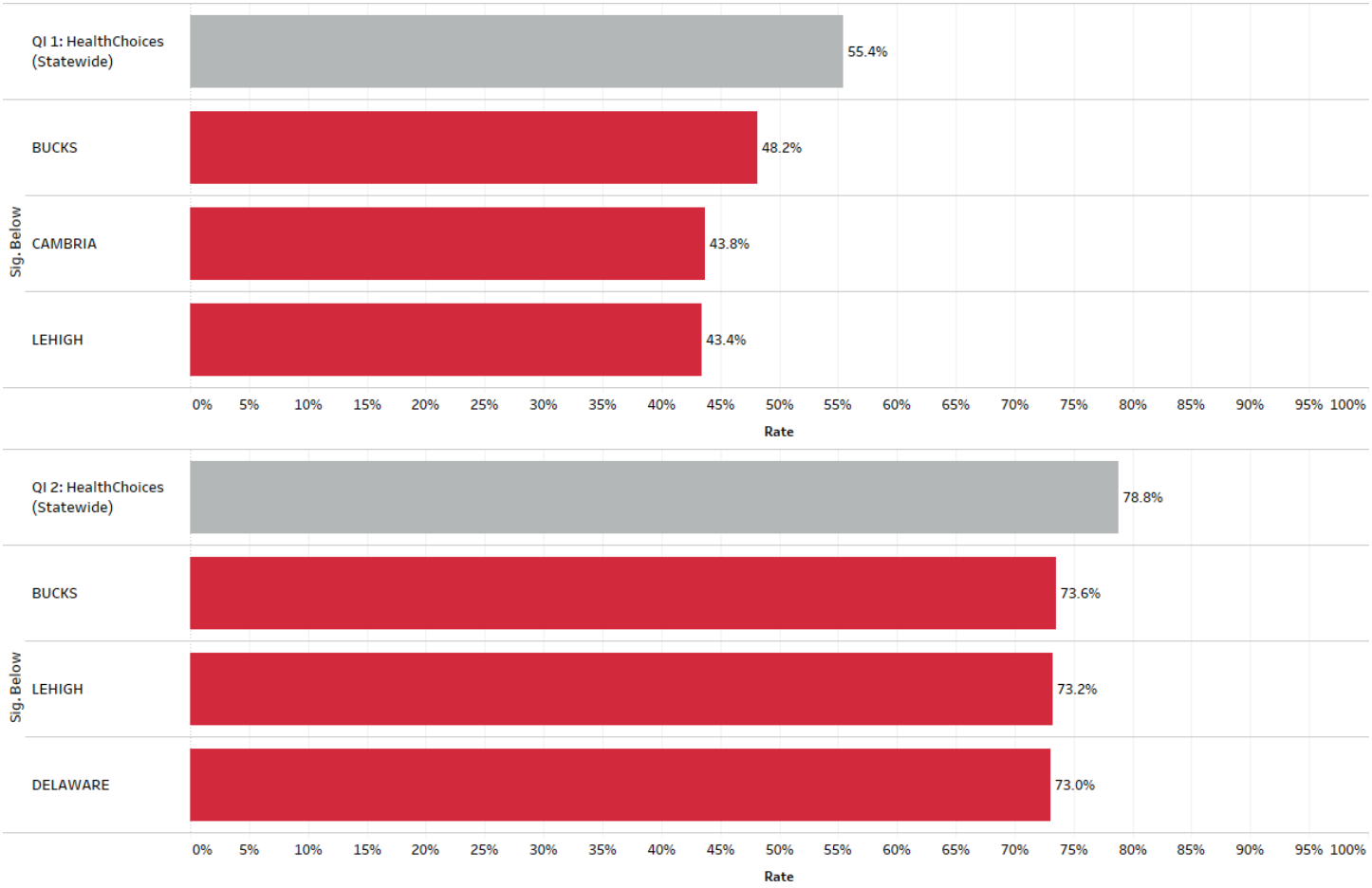

Figure 2.6: MBH Contractor MY 2019 HEDIS FUH 7- and 30-Day Follow-Up Rates (6–17 Years) that are Significantly Different than HC BH (Statewide) MY 2019 HEDIS FUH Follow-Up Rates (6–17 Years).

II: PA-Specific Follow-Up Indicators

(a) Overall Population: 6+ Years Old

Table 2.4 shows the MY 2019 PA-specific FUH 7- and 30-day follow-up indicators compared to MY 2018.

Table 2.4: MY 2019 PA-Specific FUH 7- and 30-Day Follow-up Indicators (All Ages)

	MY 2019					MY 2018	MY 2019 Rate Comparison to MY 2018	
				95% CI				
Measure	(N)	(D)	%	Lower	Upper	%	PPD	SSD
QI A – PA-Specific 7-Day Follow-Up (Overall)								
HC BH (Statewide)	21,098	39,900	**52.9%**	52.4%	53.4%	53.1%	-0.2	NO
Magellan	3,642	7,081	**51.4%**	50.3%	52.6%	50.4%	1.1	NO
Bucks	588	1,147	**51.3%**	48.3%	54.2%	50.1%	1.2	NO
Cambria	280	559	**50.1%**	45.9%	54.3%	45.8%	4.3	NO
Delaware	606	1,289	**47.0%**	44.2%	49.8%	46.4%	0.6	NO
Lehigh	792	1,549	**51.1%**	48.6%	53.7%	52.1%	-1.0	NO
Montgomery	883	1,613	**54.7%**	52.3%	57.2%	53.6%	1.1	NO
Northampton	493	924	**53.4%**	50.1%	56.6%	50.9%	2.5	NO
QI B – PA-Specific 30-Day Follow-Up (Overall)								
HC BH (Statewide)	27,741	39,900	**69.5%**	69.1%	70.0%	69.6%	-0.0	NO
Magellan	4,792	7,081	**67.7%**	66.6%	68.8%	66.2%	1.5	NO
Bucks	754	1,147	**65.7%**	62.9%	68.5%	63.8%	1.9	NO
Cambria	401	559	**71.7%**	67.9%	75.6%	65.5%	6.3	YES
Delaware	800	1,289	**62.1%**	59.4%	64.8%	60.5%	1.6	NO
Lehigh	1,073	1,549	**69.3%**	66.9%	71.6%	68.3%	0.9	NO
Montgomery	1,106	1,613	**68.6%**	66.3%	70.9%	68.7%	-0.1	NO
Northampton	658	924	**71.2%**	68.2%	74.2%	69.8%	1.4	NO

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 rates.
MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set; FUH: Follow-up After Hospitalization; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

Figure 2.7 is a graphical representation of the MY 2019 PA-specific follow-up rates for MBH and its associated Primary Contractors. The orange line indicates the MCO average.

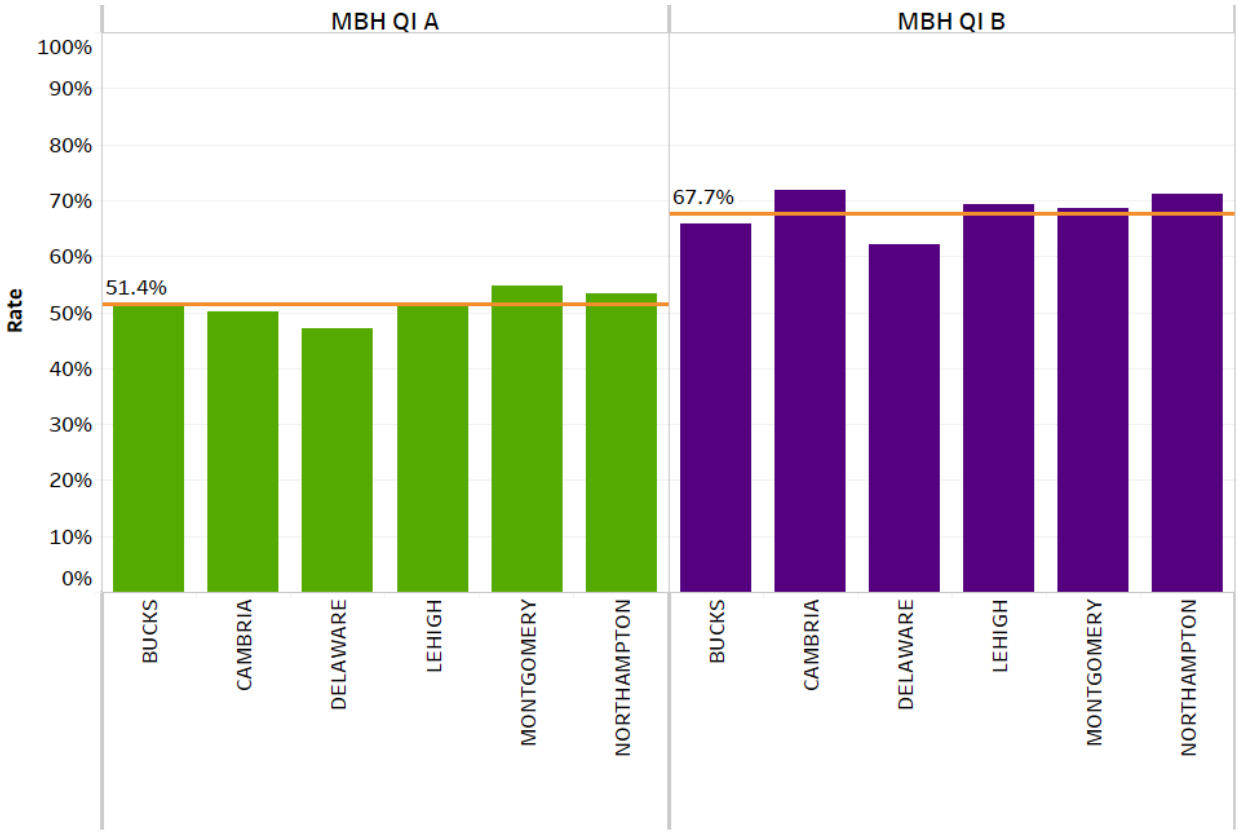

Figure 2.7: MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages).

Figure 2.8 shows the HC BH (Statewide) rates and the individual Primary Contractor rates that were statistically significantly higher or lower than the Statewide benchmark.

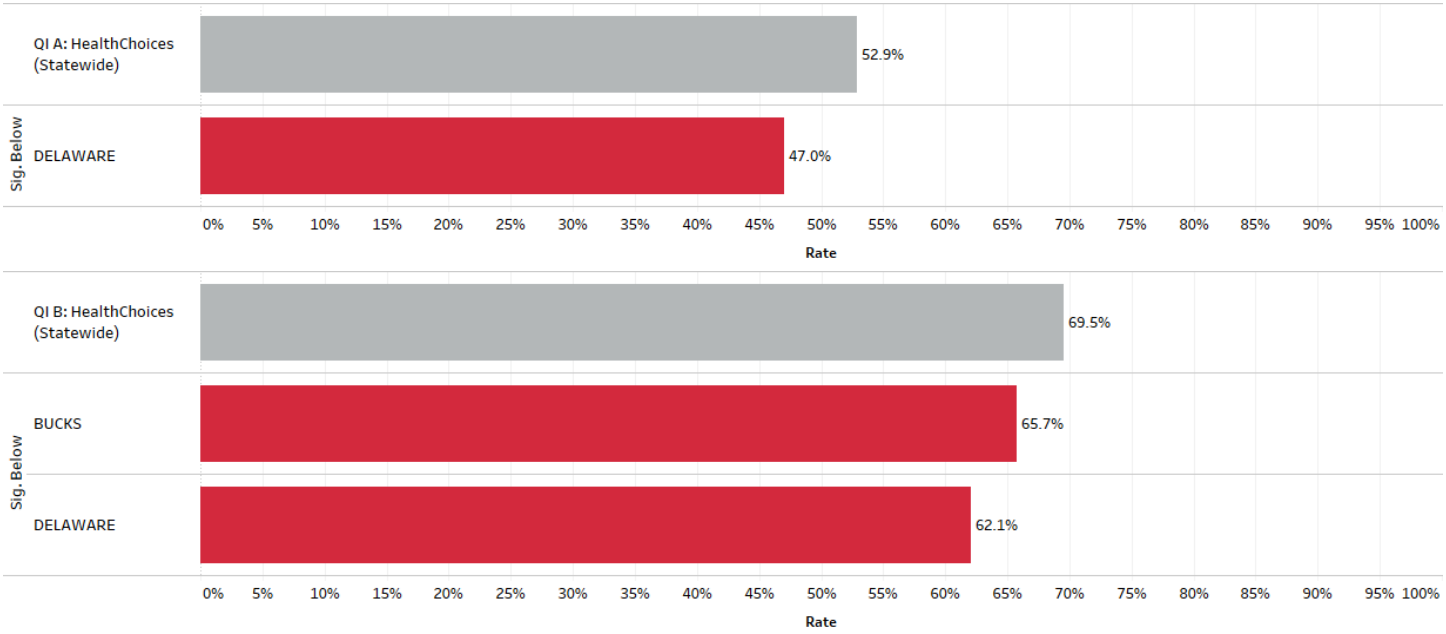

Figure 2.8: MBH Contractor MY 2019 PA-Specific FUH 7- and 30-Day Follow-Up Rates (All Ages) that are Significantly Different than HC BH (Statewide) MY 2019 PA-Specific FUH Follow-Up Rates (All Ages).

Conclusion and Recommendations

As with most reporting years, it is important to note that there were some changes to the HEDIS 2019 specifications, including revision of the denominator to include members with a principal diagnosis of intentional self-harm. That said, efforts should continue to be made to improve Follow-Up After Hospitalization for Mental Illness performance, particularly for those BH-MCOs that performed below the HC BH Statewide rate. Following are recommendations that are informed by the MY 2019 review:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2019, which included actions taken as part of the previous PIP cycle, to promote continuous quality improvement with regard to timely follow-up care after psychiatric hospitalization. The information contained in this study should be used to further develop strategies for improving the likelihood that at-risk members will receive follow-up care. BH-MCOs are expected to demonstrate meaningful improvement in behavioral health follow-up rates in the next few years as a result of their interventions. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at improving behavioral health care follow-up. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to receiving follow-up care and then implement action and monitoring plans to further increase their rates.
- It is essential to ensure that improvements are consistent, sustained across measurement years, and applicable to all groups. This year's findings indicate that, with some notable Primary Contractor exceptions, FUH rates have, for the most part increased (improved) for the BH-MCO, although overall 7- and 30-day follow-up rates for the MCO remain below the HEDIS Quality Compass 75th percentile. As previously noted, although not enumerated in this report, further stratified comparisons such Medicaid Expansion versus non-Medicaid Expansion, were carried out in a separate 2019 (MY 2019) FUH "Rates Report" produced by the EQRO and made available to BH-MCOs in an interactive Tableau workbook. BH-MCOs and Primary Contractors should review their data mechanisms to accurately identify this population. Previous recommendations still hold. For example, it is important for BH-MCOs and Primary Contractors to analyze performance rates by racial and ethnic categories and to target the populations where racial and ethnic disparities may exist. The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit lower follow-up rates. Further, it is important to examine regional trends in disparities. For instance, previous studies indicate that African Americans in rural areas have disproportionately low follow-up rates, which stands in contrast to the finding that overall follow-up rates are generally higher in rural areas than in urban areas. Possible reasons for racial-ethnic disparities include access, cultural competency, and community factors; these and other drivers should be evaluated to determine their potential impact on performance. The aforementioned 2020 (MY 2019) FUH Rates Report is one source BH MCOs can use to investigate potential health disparities in FUH.
- BH-MCOs and Primary Contractors are encouraged to review the 2020 (MY 2019) FUH Rates Report in conjunction with the corresponding 2020 (MY 2019) inpatient psychiatric readmission Rates (REA) Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission in less than 30 days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.
- CCBH turned in 7-day follow-up rates that met or exceeded the HEDIS 2019 75th percentile. Other BH-MCOs could benefit from drawing lessons or at least general insights from their successes.

Readmission Within 30 Days of Inpatient Psychiatric Discharge

In addition to Follow-Up After Hospitalization for Mental Illness, OMHSAS elected to retain and remeasure the Readmission Within 30 Days of Inpatient Psychiatric Discharge indicator for this year's EQR. As directed by OMHSAS, IPRO developed the PM for implementation in 2008. Although initiated in 2008, OMHSAS requested that the first study in this area be focused on MY 2006 data. OMHSAS required the BH-MCOs to perform another data collection and remeasurement of the PM for validation soon thereafter for MY 2007, and then for MY 2008. Remeasurements were conducted in 2010, 2011, and 2012 on MY 2009, 2010, and 2011 data, respectively. The MY 2019 study conducted in 2019 was the 11th remeasurement of this indicator. Four clarifications were made to the specifications for MY 2013. If a member was known to have multiple member IDs in the measurement year, BH-MCOs were required to combine the eligibility and claims data into a single ID prior to producing the data. BH-MCOs were reminded that denied claims must be included in this measure, and that they must use the original procedure and revenue code submitted on the claim. Finally, clarification was issued on how to distinguish between a same-day readmission and a transfer to another acute

facility. As with the Follow-up After Hospitalization for Mental Illness measure, the rate provided are aggregated at the HC BH (Statewide) level for MY 2019. This measure continued to be of interest to OMHSAS for the purposes of comparing Primary Contractor and BH-MCO rates to the OMHSAS performance goal and to prior rates.

This study examined behavioral health services provided to members participating in the HC BH Program. For the indicator, the criteria specified to identify the eligible population were product line, age, enrollment, anchor date, and event/diagnosis. In order to identify the administrative numerator-positives, the date-of-service, and diagnosis/procedure code criteria were outlined, as well as were other specifications as needed. This measure's calculation was based on administrative data only.

This PM assessed the percentage of discharges for enrollees from inpatient acute psychiatric care that were followed by an inpatient acute psychiatric care readmission within 30 days of the previous discharge.

Eligible Population

The entire eligible population was used for all 67 counties and 25 Primary Contractors participating in the MY 2019 study. Eligible cases were defined as those members in the HC BH Program who met the following criteria:

- Members with one or more hospital discharges from any inpatient acute psychiatric care facility with a discharge date occurring between January 1 and December 1, 2019;
- A principal ICD-9- or ICD-10-CM diagnosis code indicating one of the specified mental health disorders;
- Enrolled on date of discharge from the first hospitalization event and on the date of admission of the second discharge event; and
- The claim was clearly identified as a discharge.

The numerator comprised members who were readmitted to inpatient acute psychiatric care within 30 days of the previous inpatient psychiatric discharge.

Methodology

A cross-sectional quality improvement study design was employed. The source for all information was administrative data provided to IPRO by the BH-MCOs. The source for all administrative data was the BH-MCOs' transactional claims systems. The BH-MCOs were given the opportunity for resubmission, as necessary.

Performance Goals

OMHSAS designated the performance measure goal as better than (i.e., less than) or equal to 10.0% for the participating BH-MCOs and counties. For this measure, lower rates indicate better performance.

Findings

BH-MCO and Primary Contractor Results

The results are presented at the BH-MCO and then Primary Contractor level. Year-to-year comparisons of MY 2019 to MY 2018 data are provided. Additionally, as appropriate, disparate rates were calculated for various categories in the current study. The significance of the difference between two independent proportions was determined by calculating the *Z* score. Statistically significant difference (SSD) at the 0.05 level between groups is noted, as well as the Percentage Point Difference (PPD) between the rates.

Individual rates were also compared to the categorical average. Rates statistically significantly above or below the average are indicated.

Lastly, aggregate rates were compared to the OMHSAS-designated PM goal of 10.0%. Individual BH-MCO and Primary Contractor rates are *not* required to be statistically significantly below 10.0% in order to meet the PM goal (**Table 2.5**).

Table 2.5: MY 2019 REA Readmission Indicators

Measure	MY 2019 (N)	MY 2019 (D)	MY 2019 %	95% CI Lower	95% CI Upper	Goal Met? [1]	MY 2018 %	MY 2019 Rate Comparison to MY 2018 PPD	MY 2019 Rate Comparison to MY 2018 SSD
Inpatient Readmission									
HC BH Statewide	6,803	50,310	**13.5%**	13.2%	13.8%	NO	13.7%	-0.2	NO
Magellan	1,430	9,321	**15.3%**	14.6%	16.1%	NO	16.0%	-0.7	NO
Bucks	259	1,562	**16.6%**	14.7%	18.5%	NO	16.7%	-0.2	NO
Cambria	103	702	**14.7%**	12.0%	17.4%	NO	15.2%	-0.6	NO
Delaware	245	1,712	**14.3%**	12.6%	16.0%	NO	13.5%	0.8	NO
Lehigh	305	1,999	**15.3%**	13.7%	16.9%	NO	18.8%	-3.5	YES
Montgomery	336	2,141	**15.7%**	14.1%	17.3%	NO	15.6%	0.1	NO
Northampton	182	1,205	**15.1%**	13.0%	17.2%	NO	14.9%	0.2	NO

[1]The OMHSAS-designated performance measure goal is a readmission rate at or below 10%.

Due to rounding, a PPD value may slightly diverge from the difference between the MY 2019 and MY 2018 rates.

MY: measurement year; REA: Readmission within 30 Days of Inpatient Psychiatric Discharge; CI: confidence interval; N: numerator; D: denominator; PPD: percentage point difference; SSD: statistically significant difference.

Figure 2.9 is a graphical representation of the MY 2019 readmission rates for MBH and its associated Primary Contractor. The orange line represents the MCO average.

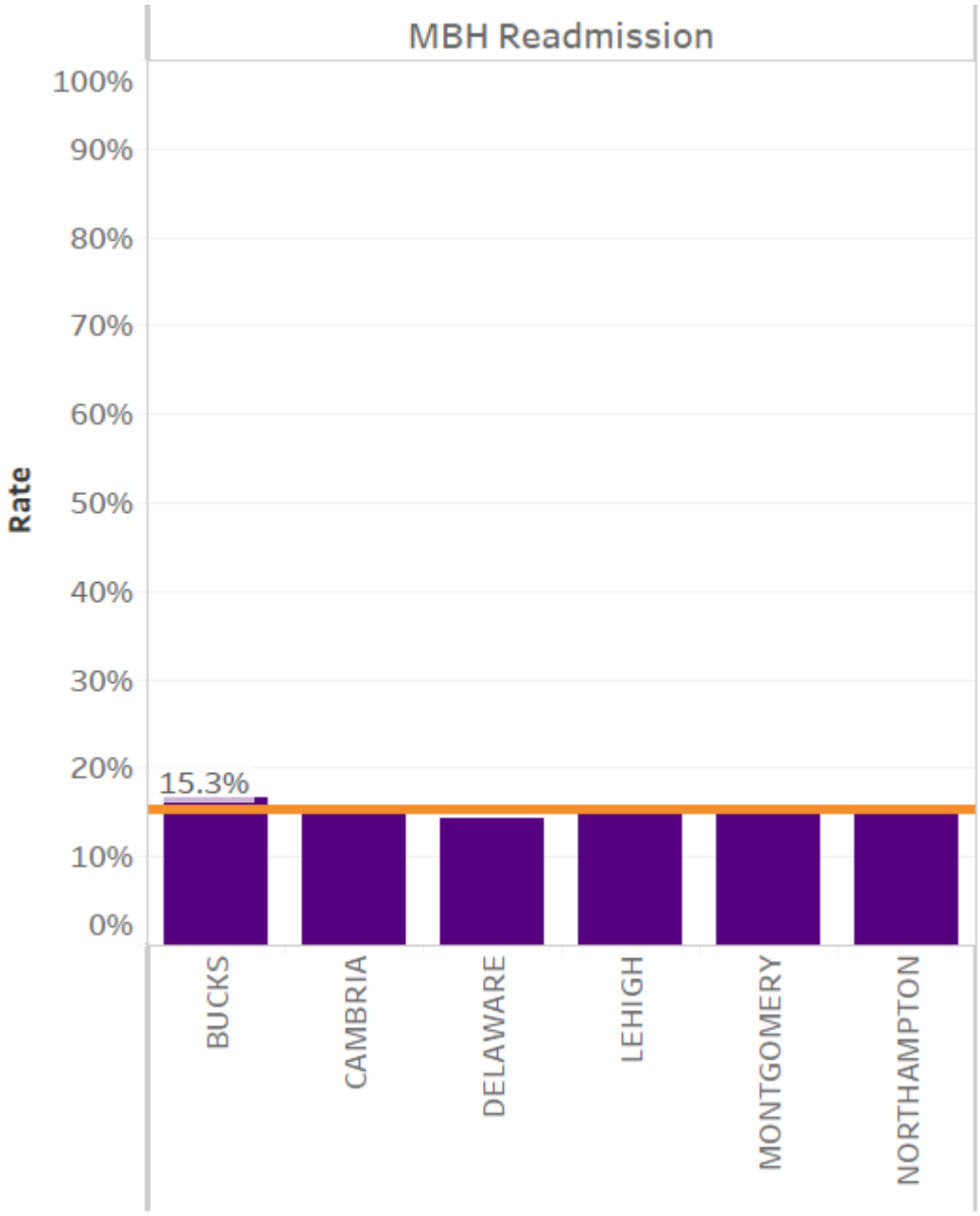

Figure 2.9: MY 2019 REA Readmission Rates for MBH Primary Contractors.

Figure 2.10 shows the Health Choices BH (Statewide) readmission rate and the individual MBH Primary Contractors that performed statistically significantly higher (red) or lower (blue) than the HC BH Statewide rate.

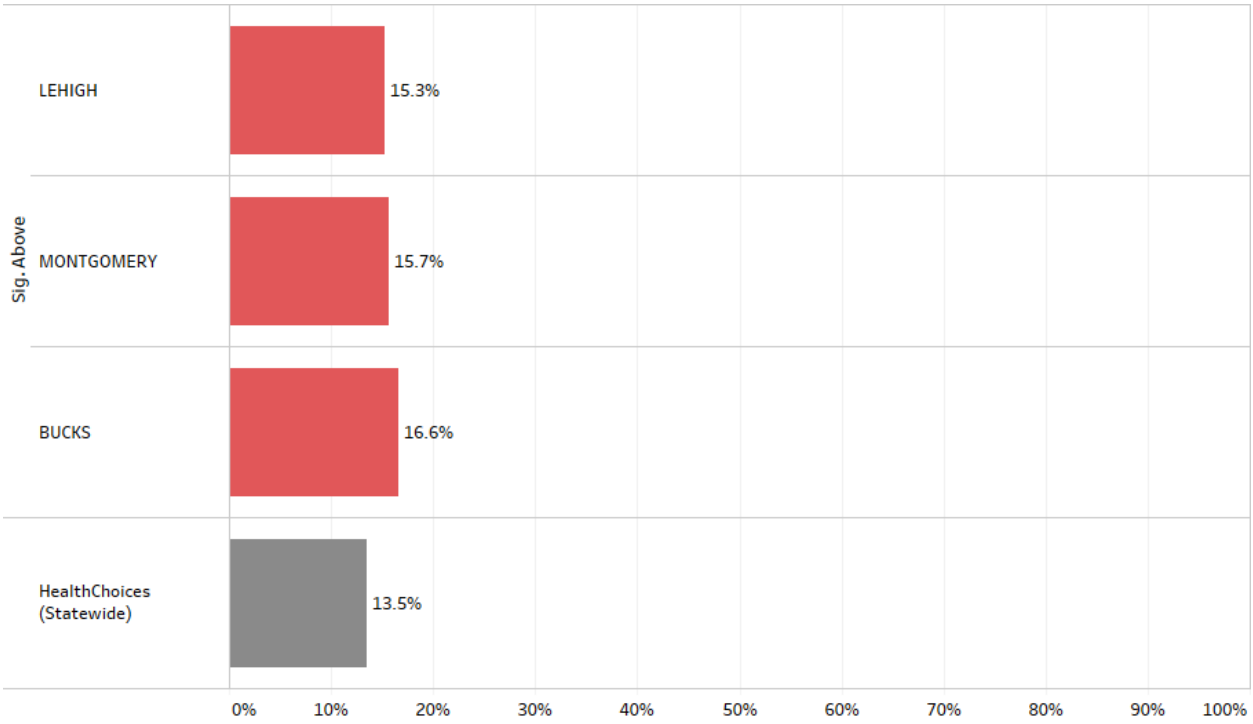

Figure 2.10: MBH MY 2019 REA Readmission Rates (All Ages) that are Significantly Different than HC BH (Statewide) MY 2019 REA Readmission Rates (All Ages).

Conclusion and Recommendations

Continued efforts should be made to improve performance with regard to Readmission Within 30 Days of Inpatient Psychiatric Discharge, particularly for those BH-MCOs and Primary Contractors that did not meet the performance goal, and/or performed below the HC BH Statewide rate.

MY 2019 saw a general decrease (improvement) for the MCO in readmission rates after psychiatric discharge. Nevertheless, MBH's readmission rates after psychiatric discharge for the Medicaid Managed Care (MMC) population remains above 10% (and statistically significantly above the HC BH Statewide average). As a result, many recommendations previously made remain pertinent. Additionally, OMHSAS continues to examine strategies that may facilitate improvement in this area. In consideration of preliminary work conducted and the past PIP cycle, the recommendations may assist in future discussions.

In response to the 2019 study, the following general recommendations are applicable to all five participating BH-MCOs:

- The purpose of this remeasurement study is to inform OMHSAS, the Primary Contractors, and the BH-MCOs of the effectiveness of the interventions implemented between 2012 and 2019 to promote continuous quality improvement with regard to mental health discharges that result in a readmission. The information contained within this study should be used to further develop strategies for decreasing the likelihood that at-risk members will be readmitted. In 2018, the BH-MCOs concluded a PIP that focused on improving transitions to ambulatory care from inpatient psychiatric services. BH-MCOs are expected to sustain meaningful improvement in BH readmission rates going forward as a result of the PIP. To that end, the Primary Contractors and BH-MCOs participating in this study should identify interventions that are effective at reducing BH readmissions. The Primary Contractors and BH-MCOs should continue to conduct additional root cause and barrier analyses to identify further impediments to successful transition to ambulatory care after an acute inpatient psychiatric discharge and then implement action and monitoring plans to further decrease their rates of readmission.
- The BH-MCOs and Primary Contractors should continue to focus interventions on populations that exhibit higher readmission rates (e.g., urban populations). Comparisons among demographic groups were carried out in a separate

2020 (MY 2019) REA "Rates Report" produced by the EQRO which is being made available to BH MCOs in an interactive Tableau workbook.

- BH-MCOs and Primary Contractors are encouraged to review the 2020 (MY 2019) REA Rates Report in conjunction with the aforementioned 2020 (MY 2019) FUH Rates Report. The BH-MCOs and Primary Contractors should engage in a focused review of those individuals who had an inpatient psychiatric readmission in less than 30 days to determine the extent to which those individuals either did or did not receive ambulatory follow-up/aftercare visit(s) during the interim period.

III: Compliance with Medicaid Managed Care Regulations

This section of the EQR report presents a review by IPRO of the BH-MCO's compliance with the MMC structure and operations standards. In review year (RY) 2019, 67 Pennsylvania counties participated in this compliance evaluation.

Operational reviews are completed for each HC Oversight Entity. The Primary Contractor, whether contracting with an Oversight Entity arrangement or not, is responsible for their regulatory compliance to federal and state regulations and the HC BH PS&R Agreement compliance. The HC BH PS&R Agreement includes the Primary Contractor's responsibility for the oversight of BH-MCO's compliance.

Bucks, Cambria, Delaware, Lehigh, Montgomery, and Northampton Counties hold contracts with MBH. All counties associated with MBH are individual Primary Contractors. In Calendar Year 2017 Cambria County moved from Beacon Health Organization (BHO) to MBH. If a County is contracted with more than one BH-MCO in the review period, compliance findings for that County are not included in the Structure and Operations section for either BH-MCO for a 3-year period. **Table 3.1** shows the name of the HC Oversight Entity, the associated HC Primary Contractor(s), and the county(ies) encompassed by each Primary Contractor.

Table 3.1: HealthChoices Oversight Entities, Primary Contractors and Counties

HC Oversight Entity	Primary Contractor	County
Bucks County Behavioral Health	Bucks County	Bucks County
Behavioral Health of Cambria County (BHoCC)	Cambria County	Cambria County
Delaware County – DelCare Program	Delaware County	Delaware County
Lehigh County HealthChoices	Lehigh County	Lehigh County
Montgomery County Behavioral Health	Montgomery County	Montgomery County
Northampton County HealthChoices	Northampton County	Northampton County

HC: HealthChoices; BH: behavioral health.

Methodology

The findings in this section of the report are based on IPRO's assessment of data provided by OMHSAS resulting from the evaluation of MBH by OMHSAS monitoring staff within the past 3 review years (RYs 2019, 2018, and 2017). These evaluations are performed at the BH-MCO and HC Oversight Entity levels, and the findings are reported in OMHSAS's PEPS Review Application for 2020. OMHSAS opts to review compliance standards on a rotating basis due to the complexities of multi-county reviews. Some standards are reviewed annually, while others are reviewed triennially. In addition to those standards reviewed annually and triennially, some substandards are considered Readiness Review items only. Substandards reviewed at the time of the Readiness Review upon initiation of the HC BH Program contract are documented in the RAI. If the Readiness Review occurred within the 3-year time frame under consideration, the RAI was provided to IPRO. For those HC Oversight Entities and BH-MCOs that completed their Readiness Reviews outside of the current 3-year time frame, the Readiness Review substandards were deemed as complete. As necessary, the HC BH Program's PS&R are also used.

Data Sources

The documents informing the current report include the review of structure and operations standards completed by OMHSAS in August 2019 and entered into the PEPS Application as of March 2020 for RY 2019. Information captured within the PEPS Application informs this report. The PEPS Application is a comprehensive set of monitoring standards that OMHSAS staff reviews on an ongoing basis for each HC Oversight Entity/BH-MCO. Within each standard, the PEPS Application specifies the substandards or items for review, the supporting documents to be reviewed to determine compliance with each standard, the date of the review, the reviewer's initials, and an area in which to collect or capture additional reviewer comments. Based on the PEPS Application, an HC Oversight Entity/BH-MCO is evaluated against substandards that crosswalk to pertinent BBA regulations ("categories"), as well as against related supplemental OMHSAS-specific PEPS Substandards that are part of OMHSAS's more rigorous monitoring criteria.

At the implementation of the PEPS Application in 2004, IPRO evaluated the standards in the PEPS Application and created a crosswalk to pertinent BBA regulations. For standards with substandards, all of the substandards within the standard informed the compliance determination of the corresponding BBA category. In 2009, as requested by OMHSAS,

IPRO conducted a re-assessment of the crosswalk to distinguish the substandards required for fulfilling BBA requirements and those that are supplemental (i.e., state-specific) as part of OMHSAS's ongoing monitoring. In the amended crosswalk, the supplemental substandards no longer contribute to the compliance determination of the individual BBA categories. For example, findings for PEPS Substandards concerning first-level complaints and grievances inform the compliance determination of the BBA categories relating to Federal and State Grievance Systems Standards. All of the PEPS Substandards concerning second-level complaints and grievances are considered OMHSAS-specific Substandards, and their compliance statuses are not used to make the compliance determination of the applicable BBA category.

In accordance with the updates to the CMS EQRO Protocols released in late 2019,[20] IPRO updated the substandards crosswalk to reflect the changes to the organization and content of the relevant BBA provisions. The CMS updates included updates to the BBA provisions, which are now required for reporting. The standards that are subject to EQR review are contained in 42 C.F.R. 438, Subparts D and E, as well as specific requirements in Subparts A, B, C, and F to the extent that they interact with the relevant provisions in Subparts D and E. In addition, findings for RY 2019 are presented here under the new rubric of the three "CMS sections": Standards, including Enrollee rights and protections, Quality assessment and performance improvement (QAPI) program, and Grievance system. Substandard tallies for each category and section roll-up was correspondingly updated.

From time to time, standards or substandards may be modified to reflect updates to the Final Rule and corresponding BBA provisions. Standards or substandards that are introduced or retired are done so following the rotating 3-year schedule for all five BH-MCOs. This may, in turn, change the category tally of standards from one reporting year to the next. In 2019 (RY 2018), two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). ID numbers for some existing substandard also changed. For this report, in order to distinguish substandards, a parenthetical notation "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its 3-year review (in RY 2020).

As was done for prior technical reports, review findings pertaining to the required BBA regulations are presented in this chapter. The review findings for selected OMHSAS-specific Substandards are reported in **Appendix C**. The RY 2019 crosswalks of PEPS Substandards to pertinent BBA regulations and to pertinent OMHSAS-specific PEPS Substandards can be found in **Appendix A** and **Appendix B**, respectively.

Because OMHSAS's review of the HC Oversight Entities and their subcontracted BH-MCOs occurs over a 3-year cycle, OMHSAS has the flexibility to assess compliance with the review standards on a staggered basis, provided that all BBA categories are reviewed within that time frame. The 3-year period is alternatively referred to as the Active Review period. The PEPS Substandards from RY 2019, RY 2018, and RY 2017 provided the information necessary for the 2019 assessment. Those triennial standards not reviewed through the PEPS system in RY 2019 were evaluated on their performance based on RY 2018 and/or RY 2017 determinations, or other supporting documentation, if necessary. For those HC Oversight Entities that completed their Readiness Reviews within the 3-year time frame under consideration, RAI Substandards were evaluated when none of the PEPS Substandards crosswalked to a particular BBA category were reviewed.

For MBH, a total of 72 unique substandards were applicable for the evaluation of HC Oversight Entity/BH-MCO compliance with the BBA regulations for this review cycle or period (RYs 2019, 2018, and 2017). In addition, 18 OMHSAS-specific Substandards were identified as being related to, but are supplemental to, the BBA regulation requirements. Some PEPS Substandards crosswalk to more than one BBA category, while each BBA category crosswalks to multiple substandards. In **Appendix C**, **Table C.1** provides a count of supplemental OMHSAS-specific Substandards that are not required as part of BBA regulations but are reviewed within the 3-year cycle to evaluate the BH-MCO and the associated HC Oversight Entity against other state-specific Structure and Operations Standards.

Program Evaluation Performance Summary Substandards Pertinent to BBA Regulations for MBH

Table 3.2 tallies the PEPs Substandard reviews used to evaluate the HC Oversight Entity/BH-MCO compliance with the BBA regulations and includes counts of the substandards that came under active review during each year of the current period (RYs 2017–2019). Substandard counts under RY 2019 comprised annual and triennial substandards. Substandard counts under RYs 2018 and 2017 comprised only triennial substandards. By definition, only the last review of annual substandards is counted in the 3-year period. Because substandards may crosswalk to more than one category, the total tally of substandard reviews in **Table 3.2**, 94, differs from the unique count of substandards that came under active review (72).

Table 3.2: Tally of Substandards Pertinent to BBA Regulations Reviewed for MBH

BBA Regulation	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
	Total	NR	2019	2018	2017
CMS EQR Protocol 3 "sections": Standards, including enrollee rights and protections					
Assurances of adequate capacity and services	5		5		
Availability of Services	24		14	4	6
Confidentiality	1			1	
Coordination and continuity of care	2		2		
Coverage and authorization of services	4		4		
Health information systems	1			1	
Practice guidelines	6		2	4	
Provider selection	3				3
Subcontractual relationships and delegation	8			8	
CMS EQR Protocol 3 "sections": Quality assessment and performance improvement (QAPI) program					
Quality assessment and performance improvement program	26		19	7	
CMS EQR Protocol 3 "sections": Grievance system					
Grievance and appeal systems	14		14		
Total	**94**		**60**	**25**	**9**

[1]The total number of substandards required for the evaluation of HC Oversight Entity/BH-MCO compliance with the BBA regulations. Any PEPS Substandards not reviewed indicate substandards that were deemed not applicable to the HC Oversight Entity/BH-MCO.
[2]The number of substandards that came under active review during the cycle specific to the review year. Because sub-standards may cross-walk to more than one category, the total tally of sub-standard reviews (94) differs from the unique count of sub-standards that came under active review (72).
RY: review year; BBA: Balanced Budget Act; MBH: Magellan Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: substandards not reviewed; NR: substandards not reviewed; N/A: category not applicable.

Determination of Compliance

To evaluate HC Oversight Entity/BH-MCO compliance with individual provisions, IPRO grouped the required and relevant monitoring substandards by provision (category) and evaluated the Primary Contractors' and BH-MCO's compliance status with regard to the PEPS Substandards. Each substandard was assigned a value of "met," "partially met," or "not met" in the PEPS Application submitted by the Commonwealth. If a substandard was not evaluated for a particular HC Oversight Entity/BH-MCO, it was assigned a value of "not determined." Compliance with the BBA provisions was then determined based on the aggregate results across the 3-year period of the PEPS items linked to each provision. If all items were met, the HC Oversight Entity/BH-MCO was evaluated as compliant; if some were met and some were partially met or not met, the HC Oversight Entity/BH-MCO was evaluated as partially compliant. If all items were not met, the HC Oversight Entity/BH-MCO was evaluated as non-compliant. A value of not applicable (N/A) was assigned to provisions for which a compliance review was not required. A value of null was assigned to a provision when none of the existing PEPS Substandards directly covered the items contained within the provision, or if it was not covered in any other documentation provided. Finally, all compliance results within a given category were aggregated to arrive at a summary compliance status for the category. For example, compliance findings relating to provider network mix and capacity are summarized under Assurances of adequate capacity and services, 42 C.F.R. § 438.207.

Format

The format for this section of the report was developed to be consistent with the categories prescribed by BBA regulations. This document groups the regulatory requirements under subject headings that are consistent with the three sections set out in the BBA regulations and described in "Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations."[21] Under each general section heading are the individual regulatory categories appropriate to those headings. IPRO's findings are therefore organized under Standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement (QAPI) program, and Grievance System.

This format reflects the goal of the review, which is to gather sufficient foundation for IPRO's required assessment of the HC Oversight Entity/BH-MCO's compliance with BBA regulations as an element of the analysis of their strengths and weaknesses. In addition, this level of analysis avoids any redundancy with the detailed level of review found in the PEPS documents.

Findings

Seventy-two (72) unique PEPS Substandards were used to evaluate MBH and its Oversight Entities compliance with BBA regulations in RY 2019.

Standards, including Enrollee Rights and Protections

The general purpose of the regulations included in this section is to ensure that each Primary Contractor/BH-MCO has written policies regarding enrollee rights, complies with applicable Federal and State laws that pertain to enrollee rights, and that the Primary Contractor/BH-MCO ensures that its staff and affiliated providers take into account those rights when furnishing services to enrollees. **Table 3.3** presents the MCO and Primary Contractor substandard findings by categories.

Table 3.3: Compliance with Standards, including Enrollee Rights and Protections

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Assurances of adequate capacity and services 42 C.F.R. § 438.207	5	Partial	Bucks, Cambria, Delaware, Montgomery, Northampton	1.1, 1.2, 1.4, 1.5, 1.6		
			Lehigh	1.1, 1.2, 1.5, 1.6	1.4	
Availability of Services 42 C.F.R § 438.206, 42 C.F.R. § 10(h)	24	Partial	Bucks, Cambria, Delaware, Montgomery	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 1.7, 23.1, 23.2, 23.3, 23.4, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 28.1, 28.2, 93.1, 93.2, 93.3, 93.4	23.5	
			Lehigh	1.1, 1.2, 1.3, 1.5, 1.6, 1.7, 23.1, 23.2, 23.3, 23.4, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6, 28.1, 28.2, 93.1, 93.2, 93.3, 93.4	1.4, 23.5	
			Northampton	1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 23.1, 23.2, 23.3, 23.4, 24.1, 24.2, 24.3, 24.4, 24.5, 24.6,	1.7, 23.5	

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
				28.1, 28.2, 93.1, 93.2, 93.3, 93.4		
Confidentiality 42 C.F.R. § 438.224	1	Compliant	All MBH Primary Contractors	120.1		
Coordination and continuity of care 42 C.F.R. § 438.208	2	Compliant	All MBH Primary Contractors	28.1, 28.2		
Coverage and authorization of services 42 C.F.R. Parts § 438.210(a–e), 42 C.F.R. § 441, Subpart B, and § 438.114	4	Compliant	All MBH Primary Contractors	28.1, 28.2, 72.1, 72.2		
Health information systems 42 C.F.R. § 438.242	1	Compliant	All MBH Primary Contractors	120.1		
Practice guidelines 42 C.F.R. § 438.236	6	Compliant	All MBH Primary Contractors	28.1, 28.2, 93.1, 93.2, 93.3, 93.4		
Provider selection 42 C.F.R. § 438.214	3	Compliant	All MBH Primary Contractors	10.1, 10.2, 10.3		
Subcontractual relationships and delegation 42 C.F.R. § 438.230	8	Compliant	All MBH Primary Contractors	99.1, 99.2, 99.3, 99.4, 99.5, 99.6, 99.7, 99.8		

MCO: managed care organization; HC: HealthChoices; BH: behavioral health; MBH: Magellan Behavioral Health; CFR: Code of Federal Regulations.

There are nine (9) categories within Standards, including Enrollee Rights and Protections. MBH was compliant with 7 categories and partially compliant with 2 categories.

For this review, 54 PEPS substandards were crosswalked to categories within Compliance with Standards, including Enrollee Rights and Protections. MBH and its Primary Contractors were reviewed on all 54 substandards. MBH and its Primary Contractors were compliant in 48 instances and partially compliant in six instances. Some PEPS Substandards apply to more than one BBA Category. As a result, one partially compliant or non-compliant rating for an individual PEPS Substandard could result in several BBA Categories with partially compliant or non-compliant ratings.

Assurances of Adequate Capacity and Services

MBH was partially compliant with Assurances of Adequate Capacity and Services due to partial compliance with one substandard within PEPS Standard 1 (RY 2019).

Standard 1: The Program must include a full array of in-plan services available to adults and children. Provider contracts are in place.

Substandard 4: BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services**).**

Availability of Services

MBH was partially compliant with Availability of Services due to partial compliance with two substandards within Standard 1 (RY 2019) and one substandard within Standard 23 (RY 2019).

Standard 1: The Program must include a full array of in-plan services available to adults and children. Provider contracts are in place.

Substandard 4: BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).

Substandard 7: Confirm FQHC providers.

Standard 23: BH-MCO shall make services available that ensure effective communication with non-English-speaking populations that include: (a) Oral Interpretation services [Interpreters or telephone interpreter services]; (b) Written Translation services, including member handbooks, consumer satisfaction forms, and other vital documents in the member's primary language (for language groups with 5% or more of the total eligible membership]; (c) Telephone answering procedures that provide access for non-English speaking members.

Limited English Proficiency (LEP) Requirements (Section 601 of Title V of the Civil Rights Act of 1964 - 42 U.S.C. Section 200d et seq.) must be met by the BH-MCO. An LEP individual is a person who does not speak English as their primary language, and who has a limited ability to read, write, speak or understand English.

Substandard 5: BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)

Quality Assessment and Performance Improvement (QAPI) Program

The general purpose of the regulations included under this subpart is to ensure that all services available under the Commonwealth's Medicaid Managed Care program, the HealthChoices Program, are available and accessible to MCO enrollees. The PEPS documents for each Primary Contractor include an assessment of the Primary Contractors/BH-MCO's compliance with regulations found in Subpart D. **Table 3.4** presents the findings by categories consistent with the regulations.

Table 3.4: Compliance with Quality Assessment and Performance Improvement Program

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Quality assessment and performance improvement program 42 C.F.R. § 438.330	26	Partial	All MBH Primary Contractors	91.1, 91.2, 91.3, 91.4, 91.5, 91.7, 91.8, 91.9, 91.10, 91.12, 91.13, 91.14, 91.15, 93.1, 93.2, 93.3, 93.4, 98.1, 98.2, 98.3, 104.1, 104.3, 104.4	91.11, 104.2	91.6

MCO: managed care organization; CFR: Code of Federal Regulations.

For this review, 26 substandards were crosswalked to Quality Assessment and Performance Improvement Program. All 26 substandards were reviewed for MBH and its Primary Contractors. MBH and its Primary Contractors were compliant with 23 substandards, partially compliant with 2 substandards, and non-compliant with 1 substandard.

Quality Assessment and Performance Improvement MCO Status

MBH was partially compliant with Quality Assessment and Performance Improvement Program due to partial compliance with one substandard within Standard 91 (RY 2019) and one substandard within Standard 104 (RY 2019) and non-compliance with one substandard within Standard 91 (RY 2019).

Standard 91: Completeness of the BH-MCO's Quality Management (QM) Program Description and QM Work Plan. The BH-MCO has a quality management program that includes a plan for ongoing quality assessment and performance improvement. The BH-MCO conducts performance improvement projects (PIPs) that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The QM plans emphasize high-volume and high-risk services and treatment including BHRS.

Substandard 6: The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.

Substandard 11: The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.

Standard 104: There is a provision for regular reporting to the Department of Human Services (DHS) on accurate and timely QM data.

Substandard 2: The BH MCO must submit data to DHS, as specified by DHS, that enables the measurement of the BH-MCO's performance. QM program description must outline timeline for submission of QM program description, work plan, annual QM summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.

Grievance System

The general purpose of the regulations included under this subpart is to ensure that enrollees have the ability to pursue grievances. The PEPS documents include an assessment of the Primary Contractor/BH-MCO's compliance with regulations found in Subpart F. **Table 3.5** presents the findings by categories consistent with the regulations.

Table 3.5: Compliance with Grievance System

Federal Category and CFR reference	Category Substandard Count	MCO Compliance Status	Primary Contractor	Substandard Status		
				Fully Compliant	Partially Compliant	Not Compliant
Grievance and appeal systems 42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	14	Partial	All MBH Primary Contractors	68.1, 68.2, 68.7, 71.2, 71.4, 71.7, 72.1, 72.2	68.3, 68.4, 68.9, 71.1, 71.3, 71.9	

MCO: managed care organization; CFR: Code of Federal Regulations.

For this review, 14 substandards were crosswalked to Grievance System. All 14 substandards were reviewed for MBH and its Primary Contractors. MBH and its Primary Contractors were compliant with 8 substandards and partially compliant with 6 substandard.

Grievance and Appeal Systems

MBH was partially compliant with Grievance and Appeal Systems due to partial compliance with 3 substandards of PEPS Standard 68 and 3 substandards of Standard 71 (RY 2019).

Standard 68: The Complaint and Fair Hearing processes, procedures and Member rights related to the processes are made known to Members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

Substandard 3: 100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

Substandard 4: Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).

Substandard 9: Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.

Standard 71: The Grievance and Fair Hearing processes, procedures and Member rights related to the processes are made known to Members, BH-MCO staff and the provider network through manuals, training, handbooks, etc.

Substandard 1: Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: 1. Internal, 2. External, 3. Expedited, 4. Fair Hearing.

Substandard 3: 100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.

Substandard 9: Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.

IV: Quality Studies

The purpose of this section is to describe quality studies performed in 2019 for the HealthChoices population. The studies are included in this report as optional EQR activities that occurred during the Review Year.[22]

Certified Community Behavioral Health Clinics

On July 1, 2017, Pennsylvania launched its SAMHSA-funded Certified Community Behavioral Health Clinics (CCBHCs) Demonstration Project ("Demonstration") to run through June 30, 2019. The purpose of the Demonstration is to develop and test an all-inclusive (and all-payer) prospective payment system model for community clinics to integrate behavioral and physical health care services in a more seamless manner. The model is centered on the provision of nine core services. Crisis services, behavioral health screening, assessment and diagnosis, treatment planning, and outpatient mental health and substance use services, along with outpatient clinic primary care screening and monitoring, are provided or managed directly by the CCBHCs. The other services, including targeted case management, peer support, psychiatric rehabilitation services, and intensive community-based mental health care to members of the armed forces and veterans may be provided through a contract with a Designated Collaborating Organization (DCO). To receive CCBHC certification, clinics also had to provide a minimum set of evidence-based practices (EBP), which was selected based on community needs assessments and centered on recovery-oriented care and support for children, youth, and adults. Seven clinics were eventually certified and participated: Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA). In several cases, CCBHC-certified clinics shared agreements with one or more DCOs to supplement the core services provided at the clinic. The counties covered by these clinics span three BH-MCOs: CBH, CCBH, and MBH.

During Demonstration Year (DY) 1, activities focused on continuing to implement and scale up the CCBHC model within the seven clinic sites. Data collection and reporting was a centerpiece of this quality initiative in two important ways. First, the CCBHC Demonstration in Pennsylvania featured a process measure Dashboard, hosted by the EQRO through REDCap, whereby clinics were able to monitor progress on the implementation of their CCBHC model. Using the Dashboard, clinics tracked and reported on clinical activities in a range of quality domains reflecting the priorities of the initiative: clinic membership, process, access and availability, engagement, evidence-based practices, and client satisfaction. The Dashboard provided for each clinic a year-to-date (YTD) comparative display that showed clinic and statewide results on each process measure, as well as average scores for three domains of the satisfaction surveys (see below): convenience of provider location, satisfaction with provider services, and timeliness and availability of appointments. These Dashboard results were reported out to a CCBHC Stakeholder Committee at the end of each quarter.

A second important feature of the Demonstration is an assessment, to be completed at its conclusion by the EQRO, to test whether the CCBHC clinics perform significantly better over the demonstration period compared to a control group of clinics located under the same Primary Contractors as the CCBHC clinics. Measurement of performance, in terms of both quality and overall cost, will span multiple areas and scales, involving a variety of administrative sources, medical records, and other sources. Several measures in the CCBHC measure set, including the SRA-A and SRA-BH-C reported directly by clinics (primarily medical record-based), are placed in a Quality Bonus Payment (QBP) program. Throughout the two-year Demonstration, clinics performed a variety of activities to support these reporting objectives. Clinics collected and reported baseline data on quality measures. The EQRO also used SurveyMonkey to support the administration and collection of patient experience of care (PEC) surveys for adults as well as for children and youth (Y/FEC). Finally, clinics collected and reported on a quarterly basis, consumer-level files documenting various relevant characteristics of their CCBHC consumers, including housing, veteran, and insurance statuses. Throughout the process, OMHSAS and EQRO provided technical assistance focused on data collection, management, and reporting, where much of the focus was on operationalizing the quality and process measures using the clinics' data plans.

Demonstration Year 2 Results

By the end of DY 2 (June 30, 2019), the number of individuals receiving at least one core service surpassed 19,900. Many of those individuals also received some form of EBP: cognitive behavioral therapy (6,907 or 34.7%), trauma-focused interventions (1,081 or 5.4%), medication-assisted treatment (1,049 or 5.3%), parent-child interaction therapy (91 or

0.5%), and wellness recovery action plan (WRAP) (355 or 1.8%). The average number of days until initial evaluation was 5.8 days. In the area of depression screening and follow-up, more than 91% of positive screenings resulted in the documentation of a follow-up plan the same day. More than 3,300 individuals within the CCBHC program received drug and alcohol outpatient or intensive outpatient treatment during the period.

Process measures reflect important progress in increasing both the access and quality of community-based care for individuals with behavioral health conditions, but the CCBHC Demonstration quality measures are designed to more meaningfully measure the impact of these efforts. **Table 4.1** summarizes how well the CCBHC clinics did on quality measures compared to statewide and national benchmarks. No statistical tests were carried out for these comparisons.

Table 4.1: CCBHC Quality Performance compared to Statewide and National Benchmarks

Measure	CCBHC Weighted Average	Comparison		
		State Weighted Average	National Average	Description (if National)
Follow-Up Care for Children Prescribed ADHD Medication - Initiation	64.2%		43.4%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up Care for Children Prescribed ADHD Medication - Continuation	74.6%		55.5%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 7 day	13.1%		11.4%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence - 30 day	14.8%		17.8%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Mental Illness - 7 day	100%		37.9%	HEDIS 2019 Quality Compass 50th Percentile
Follow-Up After Emergency Department Visit for Mental Illness - 30 day	100%		54.3%	HEDIS 2019 Quality Compass 50th Percentile
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Initiation	15.0%	41.9%		
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), ages 18-64 - Engagement	4.8%	28.4%		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 7 day	127%	35.3%		
Follow-Up After Hospitalization for Mental Illness, ages 21 and older (FUH-A) - 30 day	22.3%	55.7%		
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 7 day	16.7%	55.2%		
Follow-Up After Hospitalization for Mental Illness, ages 6-20 (FUH-C) - 30 day	29.0%	77.7%		
Antidepressant Medication Management - Acute	52.4%	52.4%		
Antidepressant Medication Management - Continuation	32.7%	35.4%		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	51.0%	78.0%		
Diabetes Screening for People with	80.6%	88.3%		

Measure	CCBHC Weighted Average	Comparison		
		State Weighted Average	National Average	Description (if National)
Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Plan All-Cause Readmissions Rate (lower is better)	15.5%	12.6%		
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)	82.0%		35.0%	MIPS 2020 (eCQMs)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)	82.2%		39.3%	MIPS 2020 (eCQMs)
Screening for Depression and Follow-Up Plan	44.8%		37.0%	MIPS 2020 (eCQMs)
Depression Remission at Twelve Months	7.2%		12.8%	MIPS 2020 (eCQMs)
Body Mass Index (BMI) Screening and Follow-Up Plan	52.1%		47.6%	MIPS 2020 (Claims)
Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents	69.8%		79.1%	HEDIS 2019 Quality Compass 50th Percentile
Tobacco Use: Screening and Cessation Intervention	63.4%		60.4%	MIPS 2019 (CMS Web Interface Measures)
Unhealthy Alcohol Use: Screening and Brief Counseling	91.6%		68.4%	MIPS 2019 (Registry)

CCBHC: Certified Community Behavioral Health Clinics; ADHD: attention deficit/hyperactivity disorder; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; IET: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; FUH: Follow-Up After Hospitalization for Mental Illness; SAA: Adherence to Antipsychotic Medications for Individuals with Schizophrenia; MIPS: Merit-Based Incentive Pay System; eCQM: electronic Clinical Quality Measure; SRA: suicide risk assessment; MDD: major depressive disorder; BMI: body mass index; CMS: Centers for Medicare & Medicaid Services; gray-shaded cells: not applicable.

With respect to adult PEC, CCBHC clinics appeared to do about as well as their peer clinics, although no statistical tests were run to compare across all clinics. **Figure 4.1** compares CCBHC clinics to a control group of comparable clinics located under the same Primary Contractor, by comparing percentages of adults reporting satisfaction along a variety of domains, as captured by the Mental Health Statistics Improvement Program (MHSIP) Adult Consumer Experience of Care Survey.

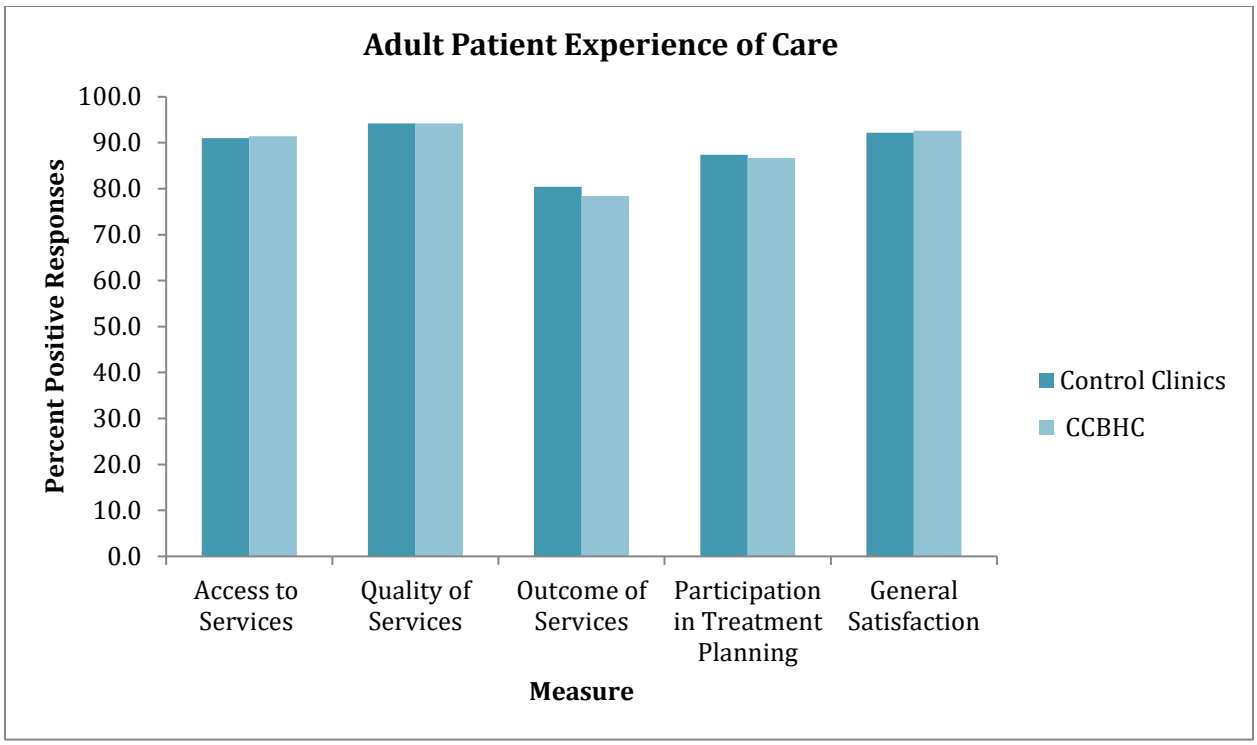

Figure 4.1: Comparison of CCBHC to Control Clinics on Adult Patient Experience of Care.

In contrast, as **Figure 4.2** shows, the percentages of children and youth reporting satisfaction with CCBHC services on the Y/FEC survey were, for the most part, higher than the percentages reported for the same domains in control clinics, although a higher percentage of control clinic clients in this age group reported satisfaction with access to services (it was also slightly higher for participation in treatment planning). Once again, these comparisons were not statistically evaluated for this study.

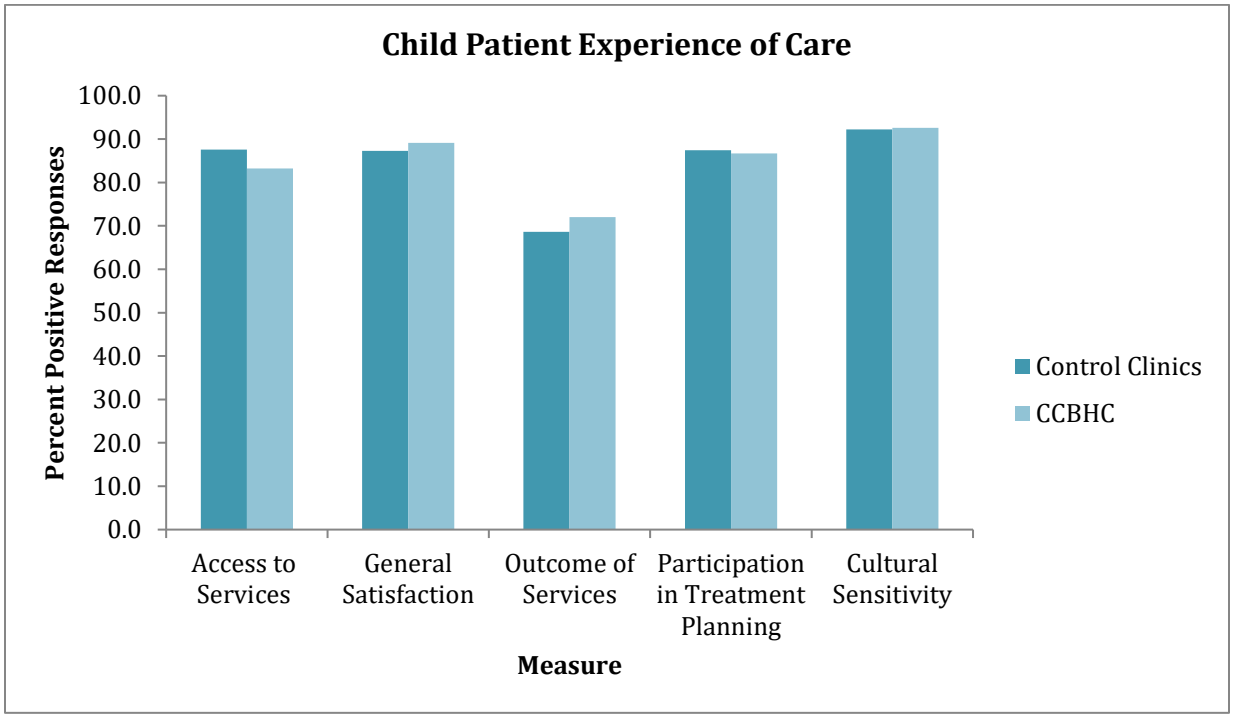

Figure 4.2: Comparison of CCBHC to Control Clinics on Child Patient Experience of Care.

Pennsylvania's CCBHC goal for patient experiences of care is to average a score of 80% or higher (normalized on a Likert Scale) for each of three major domains: convenience of provider location, timeliness and availability of appointments, and satisfaction with provider services. When grouping survey items across the three major domains, the DY 2 weighted average results for the three domains meet or surpass the yearly goal for both the PEC (n = 1,705) and Y/FEC surveys (n = 802).

Quality Bonus Payments (QBP) were also available for six of the quality measures: FUH-A (adult), FUH-C (child), IET, SAA, and SRA-A (adult), and SRA-BH-C (child). Payments were made based on percentage-point improvement over DY 1. All clinics earned QBP payments in DY 2 for at least some of the measures, with the SRA measures seeing the most sizable improvements and payouts.

Integrated Community Wellness Centers

In 2019, PA DHS made the decision to discontinue participation in the CCBHC Demonstration but to continue and build on the CCBHC model in a PA DHS-administered Integrated Community Wellness Centers (ICWC) program under an MMC agreement with CMS. Under this agreement, the same nine core services of the CCBHC model would be provided under PA's HealthChoices MMC program using a similar bundled payment arrangement with clinics certified to participate as ICWC clinics. For the first year of ICWC, 2020, the original seven clinics—Berks Counseling Center (located in Reading, PA), CenClear (with a clinic site in Clearfield, PA, and in Punxsutawney, PA), the Guidance Center (located in Bradford, PA), Northeast Treatment Centers (located in Philadelphia, PA), Pittsburgh Mercy (located in Pittsburgh, PA), and Resources for Human Development (located in Bryn Mawr, PA)—were certified to participate in the new program.

In addition, a subset of the CCBHC measures would be reported on to CMS on an annual calendar year basis, along with HEDIS Follow-up After High Intensity Care for Substance Use Disorder (FUI). The year 2020 was set as the first measurement year for ICWC. **Table 4.2** lists these measures, some of which are to be reported directly by the ICWC clinics, and some by the State, are listed here, along with a set of Dashboard ("process") measures, which will be reported to OMHSAS on a quarterly basis.

Table 4.2: ICWC Annual and Quarterly Quality Measures

Statewide Measures
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)
Follow-up Care for Children Prescribed ADHD Medication (ADD-BH)
Antidepressant Medication Management (AMM-BH)
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET-BH)
Plan All-Cause Readmission Rate (PCR)
Follow-up After Discharge from the Emergency Department for Mental Health Treatment (FUM)
Follow-Up After Discharge from the Emergency Department (FUA)
Follow-up After High Intensity Care for Substance Use Disorder (FUI)
Follow-Up After Hospitalization for Mental Illness (Adult) (FUH-BH-A)
Follow-Up After Hospitalization for Mental Illness (Child) FUH-BH-C)
ICWC Measures
Preventive Care & Screening: Body Mass Index (BMI) Screening & Follow-Up (BMI-SF)
Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)
Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (ASC)
Screening for Clinical Depression and Follow-up Plan (CDF-BH)
Weight Assessment for Children/Adolescent: Body Mass Index Assessment for Children/Adolescents (WCC-BH)
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)
Depression Remission at Twelve Months (DEP-REM-12)

Dashboard Measures
Number of referrals the ICWC make to specialty providers
Number of referrals made for veterans
Number of children (0-17) who receive at least one ICWC service in 12 months
Number of adults (18+) who receive at least one ICWC service in 12 months
Number of first contacts by ICWC members
Average number of days from contact to initial evaluation
Number of initial screenings of members age 12 to 17 and $\geq$ 18 years using a validated child depression screening tool with a (+) finding with a follow-up plan documented the same day.
Targeted Service delivery services by: Peer Support services D & A Peer Services done by Certified Recovery Specialists Telehealth
Number of unique individuals in D & A Outpatient Treatment or Intensive Outpatient Treatment

V: 2019 Opportunities for Improvement – MCO Response

Current and Proposed Interventions

The general purpose of this section is to assess the degree to which each BH-MCO has effectively addressed the opportunities for improvement cited by IPRO in the 2019 EQR Technical Report and in the 2020 (MY 2019) FUH All-Ages Goal Report.

The request for MCO response to the opportunities for improvement related to PEPS deficiencies was distributed in June 2020. The 2020 EQR Technical Report is the 13th report to include descriptions of current and proposed interventions from each BH-MCO that address the prior year's deficiencies.

The BH-MCOs are required by OMHSAS to submit descriptions of current and proposed interventions using the Opportunities for Improvement form developed by IPRO to ensure that responses are reported consistently across the Pennsylvania Medicaid BH-MCOs. These activities follow a longitudinal format and are designed to capture information relating to:

- follow-up actions that the BH-MCO has taken through June 30, 2020, to address each recommendation;
- future actions that are planned to address each recommendation;
- when and how future actions will be accomplished;
- the expected outcome or goals of the actions that were taken or will be taken; and
- the BH-MCO's process(es) for monitoring the action to determine the effectiveness of the actions taken.

The documents informing the current report include the responses submitted to IPRO as of the end of 2020, as well as any additional relevant documentation provided by the BH-MCO.

The request for MCO response to the opportunities for improvement related to MY 2019 underperformance in the HEDIS FUH All-Ages measures were distributed, along with the MY 2019 results, in January 2021. The Root Cause Analysis and Quality Improvement Plan form similarly provides for a standardized format for BH-MCOs to describe root causes of underperformance and propose a detailed quality improvement plan to address those factors, complete with a timeline of implementation-, monitoring-, and reporting activities. BH-MCOs submitted their responses by March 15, 2021.

Quality Improvement Plan for Partial and Non-compliant PEPS Standards

All actions targeting opportunities for improvement with the structure and operational standards are monitored for effectiveness by OMHSAS. Based on the OMHSAS findings for RY 2018, MBH began to address opportunities for improvement related to compliance categories within the following Subparts: C (Enrollee Rights and Protections Regulations), D (Quality Assessment and Performance Improvement), and F (Federal and State Grievance System Standards Regulations). Within Subpart C, MBH was partially compliant with Enrollee Rights. Within Subpart D, MBH was partially compliant with: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, 3) Practice Guidelines, and 4) Quality Assessment and Performance Improvement Program. MBH was non-compliant with Coordination and Continuity of Care. Within Subpart F, MBH was partially compliant with: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action, 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers and Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions. Proposed actions and evidence of actions taken by MBH were monitored through action plans, technical assistance calls, monitoring meetings, and quality and compliance reviews. OMHSAS will continue these monitoring activities until sufficient progress has been made to bring MBH into compliance with the relevant Standards.

Table 5.1 presents MBH's responses to opportunities for improvement cited by IPRO in the 2019 EQR Technical Report, detailing current and proposed interventions. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 5.1: MBH's Responses to Opportunities for Improvement

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
MBH 2019.01	Within Subpart C: Enrollee Rights and Protections Regulations, MBH was partially compliant with one out of seven categories – Enrollee Rights.	Date(s) of follow-up action taken through 6/30/20	**<u>Standard 60, Substandard 2 & 3: Training rosters identify that complaint and grievance staff has been adequately trained to handle and respond to member complaints and grievances. Include a copy of the training curriculum; Training rosters identify that current and newly hired BH-MCO staff has been trained concerning member rights and the procedures for filing a complaint and grievance. Include a copy of the training curriculum.</u>** Complaint training curriculum revised based on organizational & functional changes, and in compliance with PS&R Appendix H & Act 68. All staff, including Peer Advisors are trained on the complaint workflows and procedures. In 2016, Magellan Customer Service Associates (CSA) training for Complaints & Grievances took place on 1/13/16; and Care Management (CM) training on Complaints & Grievances took place 2/3/16. In 2017, CM and CSA training for Complaints and Grievances was conducted on 1/18/17. In 2018, in response to the Magellan PEPS CAP item: "Complaints and grievances are two different processes and need to be split into separate training curriculums for MBH staff", unique training sessions were held. Complaint Training was held on 5/2/18 and Grievance Training was held on 5/9/18 for all staff. In 2019, the annual Complaints Refresher Training was held on 7/10/19 and the Grievances Refresher Training was held on 7/24/19 for all staff.
			Following the release of Appendix H of the Program Standards and Requirements, additional trainings for staff and primary contractors were conducted on 8/22/18 (Grievances) and 8/29/18 (Complaints). To address the changes to the Program Standards and Requirements, Appendix H, Magellan hired an additional Compliance Care Manager to the

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			Complaints and Grievances Department, effective 9/10/18.
		Date(s) of future action planned-7/22/20	In 2020, the annual Complaints Refresher Training was held on 7/22/20.
		Date(s) of future action planned-8/12/20	In 2020, the annual Grievances Refresher Training was held on 8/12/20.
		Date(s) of future action planned-Ongoing	Customer Service Associates, Physicians and Care Managers will continue to receive Complaints & Grievances training on an annual basis, at a minimum. Peer Representatives, County Staff and other panel members will be trained annually in the complaint and grievance process in order to serve on the review panels. The Primary Contractors will continue to review all complaint and grievance letters upon receipt. 20% of Complaint and Grievance letters are also audited by the Primary Contractors on a quarterly basis. Five of the Primary Contractors utilize the same audit tool; results are aggregated and then feedback is given. Magellan will respond to Primary Contractor feedback and adjust procedure as applicable.
MBH 2019.02	Within Subpart D: Quality Assessment and Performance Improvement Regulations, MBH was partially compliant with four out of 10 categories and was non-compliant with one out of 10 categories within Subpart D The partially compliant categories were: 1) Availability of Services (Access to Care), 2) Coverage and Authorization of Services, and	Date(s) of follow-up action taken through 7/1/20	**Standard 28, Substandard 1: Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns:** In order to address deficiencies identified, clinical prompts within Magellan's IP system were updated. Areas addressed include: the need for Denial documentation to reflect that necessary steps are taken to seek additional clinical information to guide denial determinations, including diagnostic information, course of illness, response to treatment, symptom severity, environmental factors, and the availability of appropriate alternative services in the event of a denial and documentation of MNC. The Care

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
	3) Practice Guidelines 4) Quality assessment and performance improvement program The non-compliant category was Coordination and Continuity of Care.		Management prompts were updated in May, 2016 to ensure that Care Managers are documenting the specific MNC in clinical notes. The IP prompts were updated in September, 2017 to include/ enhance prompts for Peer Coordination and Family Visits during RTF. In March and June, 2018 IP prompts were added/ updated to support Project Red components into the Concurrent Review process. In February 2019, IP Prompts were updated to include prompts for Provider Performance Inquiry Reviews (PPIRs). In March 2019, IP prompts were updated to support Project Red components into the Concurrent Review process. In June, 2019, IP Prompts were added to address Social Determinants of Health. In July 2020, IP Prompts were updated to reflect the new ASC (Assess-Shape-Collaborate, previously known as PPIR) Referral process. The comprehensive list of updates to all IP Prompts is embedded here.
		Date(s) of follow-up action taken through 6/30/20	Trainings on Operational Effectiveness, Clinical Documentation and Active Care Management have been conducted to address clinical reviews demonstrating consistent application of medical necessity criteria and active care management that identify and address quality of care concerns. The 2017 training on Operational Effectiveness took place on 8/2/17. The 2018 Training on Operational Effectiveness was conducted for CMs on 8/1/18. The 2019 Training on Operational Effectiveness was conducted for CMs on 7/31/19.
		Date(s) of follow-up action taken through 6/30/20	Training for clinical team on BHRS level of care Guidelines was conducted on 9/27/17 to ensure adequate clinical information is collected to support determinations.
		Date(s) of follow-up action taken through 6/30/20	In 2019, the Social Determinants of Health Training was held on 9/18/19.
		Date(s) of follow-up	Workflow/ Guidelines were created to assist Care

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		action taken through 6/30/20	Managers in consistent identification and/or referral of clinical/medical quality issues to Physician Advisors.
		Date(s) of follow-up action taken through 6/30/20	The Clinical and Medical Team will educate providers about alternative levels of care during reviews and ensure that the level of care being requested is the least restrictive and medically necessary. This will be documented in IP notes. Magellan has also developed a HealthChoices Level of Care Presentation which will be available on www.MagellanofPA.com for all providers to access. Additionally, all Magellan Clinical Staff were required to take this training by 5/30/18. Care Managers and Medical Team will direct providers to the training during shaping reviews (to address consistent documentation of the consideration of alternatives when 24-hour level of care is requested to ensure the least restrictive medically necessary level of care is considered).
		Date(s) of follow-up action taken through 7/1/20	In order to ensure use of Magellan provider performance processes to address problems with providers' clinical judgment, clinical staff are trained annually on the use of PPIRs for clinical judgment issues, such as when a provider refuses to take a member into treatment or fails to respond to CM suggestions and requests. All clinical staff has the ability to file a PPIR in the QI database. In 2016, the training was conducted on 12/7/16. In 2017, the PPIR training took place on 12/6/17. In 2018, the training took place on 5/16/18. The PPIR training did not take place in 2019 due to the revamping of the PPIR process. To ensure coordination in the management of concerns with providers' performance across Magellan's QI, Clinical, Medical and Network departments, PPIR issues referred to the Provider Quality Advisory Committee (PQAC). Recommendations and suggestions from PQAC are referred to RNCC for possible network action. PPIR

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			trends and findings are also reviewed during the Quality Improvement Committee (QIC) Meeting. In 2019, Magellan and stakeholders identified that there was opportunity to enhance coordination with providers around non-emergent/non-safety related provider performance concerns. Magellan discussed this through the Quality Improvement Committee and with the Provider Quality Advisory Committee late in 2019 to coordinate efforts and obtain provider feedback on quality of care concern monitoring and improvement opportunities. From this feedback, Magellan developed an enhanced process called ASC (Assess-Shape-Collaborate) Referrals. This is the new process for identifying, reporting, tracking, and responding to non-emergent, non-safety-related concerns about provider performance. The new ASC process and its related terminology officially began 7/1/20. In the interim period between discontinuing the old non-emergent PPIR process and developing the new ASC process (January 2020-June 2020), PPIRs were being tracked and examined manually. The old definition of "trend" meaning three similar issues in a three-month period has been retired and replaced with focus on "themes" exhibited by a provider. The removal of the requirement for a trend to be established will allow Magellan to engage providers closer to real-time regarding potential areas of opportunity. The term "PPC" will only be used in reference to emergent, safety related issues identified by Quality Improvement Reviewers through the course of incident follow-up. The 2020 ASC Training took place on 7/1/20 for all staff.
		Date(s) of follow-up action taken through 6/30/20	A training was conducted regarding Intensive Behavioral Health Services (IBHS) on 12/11/19.
		Date(s) of future	The 2020 Training on Operational Effectiveness

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		action planned-7/29/20	was conducted for CMs on 7/29/20.
		Date(s) of future action planned-Ongoing	CM Training on the Operational Effectiveness is conducted annually.
		Date(s) of future action planned-12/2/20	The 2020 training on Social Determinants of Health is scheduled to take place on 12/2/20.
		Date(s) of future action planned-Ongoing	IP Prompts are monitored ongoing and as opportunities are identified to impact appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns, changes will be made accordingly.
		Date(s) of future action planned-10/7/20	A training was held on Incident Reporting for all staff on 10/7/20.
		Date(s) of future action planned-Ongoing	Training on the ASC process is conducted as needed.
		Date(s) of follow-up action taken through 6/30/20	**Standard 28, Substandard 2: The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.** In March 2016, Magellan implemented monitoring audits to ensure that the medical necessity decision made by the Physician/ Advisor is supported by documentation in the denial record and reflects the appropriate medical necessity criteria. The findings of the audits are reviewed weekly with the Clinical Department. Denial records are also formally audited on a quarterly basis by the Primary Contractors. The Primary Contractors also review all denial letters. Five of the Primary Contractors utilize the same audit tool; results are aggregated and then feedback is given. Magellan responds to Primary Contractor feedback and adjusts procedure as

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			applicable. Training for Physician Advisors was conducted on HealthChoices Levels of Care to address documentation of appropriate and available alternative services when issuing a denial. *(copy of PowerPoint Training is attached above)*
		Date(s) of follow-up action taken through 6/30/20	Training for clinical and medical team- Operational Effectiveness: Opportunities for Improvement Training was conducted on 8/4/17. The 2018 Training on Operational Effectiveness was conducted on 8/1/18. The 2019 Training on Operational Effectiveness was conducted on 7/31/19. *(copy of PowerPoint Training is attached above)*
		Date(s) of future action planned-7/29/20	The 2020 Training on Operational Effectiveness was conducted on 7/29/20. *(copy of PowerPoint Training is attached above)*
		Date(s) of future action planned-Ongoing	Training on the Operational Effectiveness is conducted annually for all clinical and medical staff.
		Date(s) of future action planned-Ongoing	Denial records are audited on a quarterly basis by all Primary Contractors. The Primary Contractors also review all denial letters. Five of the Primary Contractors utilize the same audit tool; results are aggregated and then feedback is given. Magellan responds to Primary Contractor feedback and adjusts procedure as applicable.
		Date(s) of follow-up action taken through 6/30/20	**Standard 72, Substandard 2: The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains**

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			date denial decision will take effect). Denial Notice Templates were updated to align with the language and requirements in Appendix AA of the PS&R. Notices will no longer include medical jargon and will include an explanation of member rights and procedures for filing a grievance, requesting a Fair Hearing and continuation of services. The letters also include contact information, member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect. These changes were incorporated into future trainings and review practices. Team Meeting took place on 10/24/16 with Managers of Clinical Services, Clinical Director, Senior Manager of Clinical Care Services and Manager of Appeals to address the Supervisory review practices of all denial notifications. This was also addressed during the 11/16/16 and 11/15/17 Clinical Trainings. For 2018, the annual clinical staff training on Denial Letters took place on 11/7/18. In 2019, the Denial Letters Training took place on 11/6/19.
		Date(s) of future action planned-9/2/20	The Enhancing Readability: Reducing Jargon in Member Communication Training was held on 9/2/20.
		Date(s) of future action planned-11/4/20	For 2020, the Denial Letters Training is scheduled to take place on 11/4/20.
		Date(s) of future action planned-Ongoing	Denial records are audited on a quarterly basis by all Primary Contractors. The Primary Contractors also review all denial letters. Five of the Primary Contractors utilize the same audit tool; results are aggregated and then feedback is given. Magellan responds to Primary Contractor feedback and adjusts procedure as applicable. The Primary Contractor's Audit Tool will be updated to reflect the PEPS 72 standards.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		Date(s) of follow-up action taken through 6/30/20	**<u>Standard 91, Substandard 5: The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).</u>** In the 2018 third quarter PEPS report, Magellan shared the following updates on Quality Work Plan Indicator #17: • Magellan's CHC Care Manager, who has experience working with the older adult population, joined the Magellan team in April 2018. • Magellan representatives have participated in ongoing CHC meetings with county stakeholders, such as BH, MH, AAA, and Health Departments with the goal of sharing information and collaborating on CHC implementation. • Initial workflows were developed and implemented in 2018, based on feedback received from initial collaborative meetings with the CHC MCOs. Highlighted in the workflow are details such as who can be contacted for review, how to find community providers, when a consent is needed, etc. • Care collaboration has been ongoing with all three CHC MCOs. Both Magellan and the CHC MCOs have been identifying members for clinical collaboration efforts. Additional actions and interventions for this Work Plan activity during 2018 included: • Magellan continues to meet with each CHC MCO individually, at least monthly, to discuss coordination efforts, expectations, and clinical/data needs. • Magellan uses claims information to identify members who are active with CHC and who are at higher risk for readmission. These members are then shared with the CHC MCOs, for collaboration and follow up.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			• Magellan conducts cost monitoring, level of care access monitoring and outreach to Nursing Facilities/Home Health Agencies, and contracting with BH agencies who were already co-located in Nursing Facilities. • The process of finalizing the Letters of Agreement (LOA) for the Southwest Region with each CHC MCO was finalized prior to January 2018, to allow for clinical collaboration. • Two of the three CHC MCOs have asked for claims data, to assist in developing a better understanding of their CHC population. The processes of sharing data and exchange of information will continue to be reviewed for identification of ongoing data needs and for development of a secure data sharing protocol. • Magellan has representatives at each of the CHC regional summits. For the 2019 Work Plan, because the earlier established goals were achieved, as part of the CQI process, Magellan adjusted the Objective for CHC and this is reflected now in the Quality Work Plan (#68): Objective- Magellan will participate in routine meetings to continue implementation and maintenance of the Community HealthChoices program to collaborate, coordinate and share best practices. Goal- Attend regional meetings and maintain ongoing care coordination strategies with providers. The Integrated Care Manager is the individual responsible to annually report progress to the Quality Improvement Committee. Clinical Coordination Rounds are available across contracts but occur specifically with Lehigh/Northampton Wellness Recovery Teams (WRT). Magellan supports cross system collaboration to be offered quarterly, or as needed. Magellan collaborates with Gateway and Health Partners for the Emergency Department (ED) Data Exchange Pilot which is an initiative to share

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			emergency department data for the purpose of analysis, member outreach opportunities, and identifying trends among BH providers and/or ED providers.
		Date(s) of follow-up action taken through 6/30/20	**Standard 91, Substandard 6: The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.** Magellan strives to be a community contributor and has significant involvement with community-based organizations. Below reflects a sampling of ways in which Magellan has demonstrated collaborative efforts with schools and other organizations. • Magellan routinely supports management of RFI processes to review of proposals and jointly study the need for services in the community. These review groups include many participants that collaborate on the venture, for example, representatives from Magellan, county behavioral health staff, representatives from the office of intellectual and developmental disabilities, juvenile probation, children and youth, etc. • Magellan sponsors training opportunities in the community. While Magellan does often support continuing education credits for clinicians, Magellan also supports robust offerings for the community through involvement with conferences, and trainings to encourage collaboration with other systems partners, such as to local magistrates, school districts, and emergency response teams. Specifically, Magellan has sponsored opportunities for Crisis Intervention Team (CIT) trainings. • More recently, Magellan has increased coordination with county partners to understand the impact of social determinants of health. Magellan invests Project Management resources into county supported projects, such as the "Now Is the Time (NITT): Health Transitions" grant, which is a five year

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			project working to bridge the gap between young adults and adulthood. Goals included housing, a respite program and a LGBTQI initiative (which resulted in a conference). • Magellan serves as a Collaborator in the Reducing the PA Incompetency to Stand Trial Restoration project with Northampton HC, focusing energies on increasing relationships, services and interventions with courts, prison and re-entry services as well as with our law enforcement community. • Magellan has served as a presenter at hospital based Grand Rounds. • Magellan also participates in workgroups focused on identification of community needs for specialty populations, e.g. Sepsis Treatment & Addiction Recovery (STAR) STAR program @ St. Luke's University Health Network (SLUHN), for patients diagnosed with endocarditis. This pilot allows eligible patients to be accepted at local substance abuse rehabilitation after assessment by another provider and receive home health care nursing while in treatment, rather than remain in acute hospital setting. • Magellan was a significant contributor to the Many Aspects of Prevention Summit held in May 2019, which was focused on primary, secondary and tertiary prevention. Community-focused programs included the program within Lehigh County Jail, Center of Excellence for Opioid Use Disorder at Treatment Trends, Lehigh County Blue Guardian, and the Allentown Outreach initiative. The Summit increased training and provider knowledge base surrounding use of MAT, provided an overview of Naloxone to reverse overdose, and use of Trauma Informed Care as a tool for overdose prevention. • Magellan is an active participant in the Northampton County Suicide Prevention Task Force. • As noted in the 2019 Magellan Behavioral

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			Health of Pennsylvania, Inc. Quality Management-Clinical Management Program Evaluation approved by OMHSAS in May 2020: ○ Magellan participates in a project called Bucks County Connect Assess Refer Engage Support (BCARES). This is a warm handoff collaboration between the six hospital emergency departments and an assigned certified recovery specialist (CRS) for individuals who have survived an opioid overdose. Survivors are offered a direct connection from the emergency department to treatment and recovery support services. Magellan supports the County's initiative through marketing, training, etc. ○ Magellan partners as a key participant in the Cambria County Suicide Prevention Task Force. This joint collaborative effort includes participation in monthly Task Force meetings and regular sub-committee meetings (Training & Education, Out of the Darkness Walk Committee, Fundraising, Marketing/Publicity and Loss Survivor Resources). Trainings on Suicide Prevention were provided with over 250 people trained in 2019. Training topics included: Mental Health First Aid (Adult and Youth), Question Persuade and Refer: QPR Suicide Gatekeeper Training, and safeTALK – Suicide Awareness Training. ○ Collaborative efforts in Delaware County focused on maintaining a Meeting Collaborative on Behavioral Health Supports. This involved participation and representatives from several organizations. Major accomplishments of the efforts included development of strong relationships with system partners, improved identification of members with behavioral health needs, use of screening tools in the schools, and increased referrals

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			to behavioral health services. ○ Magellan has extensive experience collaborating with school districts and other affected agencies and stakeholder organizations to implement school-based mental health programs. Most recently in 2019, Magellan collaborated with all the school districts in Lehigh and Northampton Counties to review access to mental health services within each district. The collaboration identified that over 80% of children referred for a mental health assessment as part of the Student Assistance Program (SAP) met criteria for outpatient counseling. This high rate led to identification of needing enhanced partnerships with schools and co-locating additional outpatient mental health treatment in the school settings. By working with the school and community mental health providers, offering technical assistance in setting up satellite sites in the schools resulted in 40 new school-based clinic sites. This collaboration also resulted in: ▪ Initiation of the Lehigh Valley School Mental Health Collaborative using of the University of Washington Collaborative Care in School model, an innovative approach to integrated mental health service delivery that focuses on reducing access barriers through: enhancing community partnerships, increasing service accessibility, integrating mental health, primary care, and educational providers and services, and improving service quality through increased use of evidence based practices by school-based practitioners. ▪ Partnership with the United Way of Lehigh Valley in the Handle With Care

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			program of enhanced police-school communication to better support students exposed to traumatic events and support the implementation of trauma informed school practices, including discussion on use of the Safe2Say system for Handle With Care referrals to match school protocols. ▪ One school district integration of SAP and mental health assessment into the Multi-Tiered Support Structure (MTSS) framework, a three-tiered, schoolwide approach that promotes early identification and support of students with learning and emotional/behavior needs, to improve access to the school based mental health services. ○ In 2019 collaborative efforts for Montgomery County involved coordination with the criminal justice system. Magellan maintained participation in the "Stepping Up Committee" alongside Montgomery County BH staff and HealthChoices Staff, Montgomery County Public Defenders, District Attorney, Adult Probation, the Correctional Facility, Behavioral Health providers, Drug Court, Behavioral Health Court, Homeless Services, the Montgomery County Housing Department, the Regional SCI Coordinator and Information Technology staff. Key accomplishments were noted to be development of stronger relationships with system partners, improved identification of members with SMI/SA who are currently incarcerated, ability to offer outpatient assessments to incarcerated members via telehealth thorough grant funds to help successfully divert individuals from incarceration.
		Date(s) of future action planned-Ongoing	Recommendations for the 2020 Quality Work Plan were discussed during the 10/24/19 QIC meeting. The Work Plan objective for 2020 was updated to:

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			Magellan will focus on formalized collaborative efforts to be conducted with organizations such as schools, state and local police and other community agencies. The Work Plan goal for 2020 is: Magellan participates in collaborative efforts within each contracted county.
		Date(s) of future action planned-Ongoing	Magellan intends to continue participation in collaborative workgroups in 2020.
		Date(s) of future action planned-Ongoing	Magellan intends to continue oversight of school-based outpatient expansion in 2020 through implementation oversight treatment record reviews to help ensure program expansion yields positive quality of care outcomes.
		Date(s) of follow-up action taken through 6/30/20	**Standard 91, Substandard 10: The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: Quality of individualized service plans and treatment planning Adverse incidents Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance.** To address how Magellan will assess the quality of service and treatment plans: Routine Treatment Record Review (TRR) activities include quality review of individualized service plans and treatment plans, though it is not explicitly described in the Magellan Quality Work Plan (#16) Objective: Monitor documentation practices against policies/procedures; Results shared with providers. However, attached are examples of sections of the MH and SA Tools that assess the quality of service and treatment planning during routine TRR activities, specifically Sections D, Individualized Treatment Plan & Section E, Ongoing Treatment. Each Magellan level of care auditing tool(s) contain a section dedicated to individualized treatment

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			planning/service plans. Magellan's Treatment Record Review tools are aligned with Pennsylvania regulations based on levels of care. Recommendations for the 2020 Quality Work Plan were discussed during the 10/24/19 QIC meeting. The 2020 objective is: Treatment Record Reviews (TRRs) will be utilized to monitor documentation practices against policies/procedures; findings of TRRs will be shared with providers. The 2020 goal is: Results are expected to be >85%. Providers with TRR activities not meeting the targeted goal will be addressed via action plan resolution.
		Date(s) of future action planned-Ongoing	Treatment Record Reviews include review of individualized treatment planning and the quality of those plans. This scoring is a variable reported in the overall scoring of the treatment record review.
		Date(s) of follow-up action taken through 6/30/20	**Standard 91, Substandard 11: The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.** Annually network providers are surveyed on their experience with Magellan and findings are reported by the Network Team to the Quality Improvement Committee. The survey tool demonstrates that Magellan surveys providers in the following areas of focus in the satisfaction survey including: • Referral Process • Adult Care Management Process • Child Care Management Process • Telephone Contact with Magellan Health • Reimbursement Issues (e.g. claims processing) • Credentialing • Communication • Compared to Other Managed Care Companies • Provider Training • Inquiry if the provider has interest in Magellan providing any specific topics of trainings Provider satisfaction findings are analyzed and included in the Magellan Behavioral Health of

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			Pennsylvania Inc., Clinical-Quality Annual Program Evaluation on pp. 200-205. This review includes all survey questions that were asked of providers as well a comparison to prior years. As a new survey instrument was used, Magellan is regarding 2019 provider satisfaction rates as a new baseline. Recommendations for the 2020 Quality Work Plan were discussed during the 10/24/19 QIC meeting. The 2020 objective is: Overall experience (satisfaction) with Magellan will be reported upon annually. The 2020 goal is: The annual Provider Experience report should include review of all areas of survey focus, provide a comparison of results to prior years' findings, in order to assess for areas of opportunity. Analysis should identify program strengths and opportunities. Improvement opportunities will be supported through Committee oversight.
		Date(s) of future action planned-Ongoing	Magellan has enhanced the Quality Work Plan to include specificity for provider experience and areas of survey focus and benchmarks from the previous review period in order to assess progress.
		Date(s) of follow-up action taken through 6/30/20	**Standard 91, Substandard 14: The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the annual evaluation and any corrective actions required from previous reviews.** The recommendation for the 2020 Quality Work Plan to include information on how previously issued Corrective Action Plans (CAP) are addressed was discussed during the 10/24/19 QIC meeting. As a result, a Work Plan item was added focusing on the monitoring of CAP activities. The 2020 Work Plan objective is: Magellan will address all corrective action plans (CAPs) issued by oversight agencies in a timely manner. The 2020 Work Plan goal is: Magellan will maintain compliance with regulatory requirements and Program Standards and Requirements.
		Date(s) of future	Magellan will continue to provide timely responses

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
		action planned-Ongoing	to CAPs issued by oversight agencies.
MBH 2019.03	Within Subpart F: Federal and State Grievance System Standards Regulations, MBH was partially compliant with nine out of 10 categories. The partially compliant categories were: 1) Statutory Basis and Definitions, 2) General Requirements, 3) Notice of Action 4) Handling of Grievances and Appeals, 5) Resolution and Notification: Grievances and Appeals, 6) Expedited Appeals Process, 7) Information to Providers and Subcontractors, 8) Continuation of Benefits, and 9) Effectuation of Reversed Resolutions	Date(s) of follow-up action taken through 6/30/20	**Standard 68, Substandard 1: Interview with Complaint Coordinator demonstrates a clear understanding of the complaint process, including how the compliant rights and procedures are made known to members, BH-MCO staff, and the provider network: 1. 1st level, 2. 2nd level, 3. External, 4.Expedited, 5.Fair Hearing;** Complaint script and Customer Contact Form will be updated to include all member rights and an overview of the complaint process. Attestation that member rights were reviewed with the caller will also be added to Customer Contact Form. The script and Customer Contact Form were updated in April, 2018 and then again in September 2018 to align with Appendix H changes. Complaint-specific training will be developed and held on 5/2/18. The curriculum will include the review of the complaint script, need to share all member rights and overview of complaint process at the time of the call, and attestation on the Customer Contact form that this was done. *(copy of PowerPoint Training is attached above-reference Standard 60)* Complaint-specific training incorporating the changes from Appendix H and the updated complaint workflow will be developed and held prior to 9/1/18 expected compliance. Training date was 8/29/18. *(copy of PowerPoint Training is attached above-reference Standard 60)*
			Complaint workflow updated. Magellan will attempt to obtain Member's verbal consent and mail the consent form to the Member. All attempts should be documented. As soon as verbal consent is obtained, Magellan will begin the Complaint

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			investigation/Grievance process but will not share any information with the representative. If neither verbal nor written consent is obtained, Magellan will not proceed with the Complaint investigation/Grievance process. If the Complaint involves a serious matter, i.e. Member's health & safety are at risk, Magellan will determine the course of action and if appropriate address the Complaint through the internal "administrative process." In 2019, the annual Complaints Refresher Training was held on 7/10/19. *(copy of PowerPoint Training is attached above-reference Standard 60)*
		Date(s) of future action planned-7/22/20	In 2020, the annual Complaints Refresher Training was held on 7/22/20. *(copy of PowerPoint Training is attached above-reference Standard 60)*
		Date(s) of future action planned-Ongoing	Complaint Training is conducted annually for all clinical and medical staff.
		Date(s) of follow-up action taken through 6/30/20	**Standard 68, Substandard 3: 100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established timelines. The required letter templates are utilized 100% of the time.** Complaint workflow updated. Initial member interview to be attempted prior to sending the acknowledgment notice to ensure accuracy of complaint and consistency in issues reviewed. Magellan will make 3 attempts to reach the member over 3 business days (all call attempts will be documented). Complaint decision notice will therefore include a determination regarding each issue and correspond with issues as outlined in the acknowledgment notice. *(copy of Complaint Workflow is attached above)*

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			Complaint Investigation and Decision Making Training was developed and held in January 2019 after finalization of Appendix H. Curriculum emphasized need for committee to identify follow up needs. Follow up specific to support of the member shall be documented in MBH Care Management Notes. Curriculum emphasizes need for case file to reference where documentation can be found if the follow up does not specifically pertain to the member. For supported complaints, a new Substantiated Complaint Follow-up form was developed to ensure follow-up identified by the committee is completed. Decision Letters no longer explain the entire complaint investigation process and only cite the specific resources referenced in the review.
		Date(s) of follow-up action taken through 6/30/20	**Standard 68, Substandard 4: Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s);` The Complaint Case File includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.** Complaint Investigation and Decision Making Training was developed and held on 1/30/2019, after finalization of Appendix H. The curriculum includes requirements of the investigator to document the steps planned, persons to contact and documentation to be requested. Investigator, with support of an Appeals Coordinator, will monitor providers' submission of requested documents and follow up if not provided. Investigator will attempt at minimum an initial interview with member at outset of review and a second interview prior to presentation of complaint to committee.

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			(copy of PowerPoint Training is attached above) Updated Complaint Review Summary Note clearly identifies the name, credentials, and title of the first level complaint committee member(s) and date of the complaint review. New Decision Summary Note was developed and the date of the Committee Review, participants, documentation considered and follow-up requirements is identified.
		Date(s) of follow-up action taken through 6/30/20	**Standard 68, Substandard 9: Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.** Complaint Investigation and Decision Making Training was developed and held on 1/30/2019, after finalization of Appendix H. Curriculum emphasizes need for committee to identify follow up needs. Follow up specific to support of the member is documented in MBH Care Management Notes. Curriculum emphasizes the need for case file to reference where documentation can be found if the follow up does not specifically pertain to the member. *(copy of PowerPoint Training is attached above)* Substantiated Complaints and any quality of care or compliance concerns identified during complaint reviews are discussed in Member Services Committee and QIC to consider follow-up opportunities. These are also shared as needed

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			during the Provider Quality Advisory Committee (PQAC) and county specific QM monitoring meetings. New Decision Summary Note will be developed and the date of the Committee Review, participants, documentation considered and follow-up requirements will be identified. *(copy of Decision Summary Note template is attached above)*
		Date(s) of follow-up action taken through 6/30/20	**Standard 71, Substandard 1: Interview with Grievance Coordinator demonstrates a clear understanding of the grievance process, including how grievance rights and procedures are made known to members, BH-MCO staff and the provider network: 1. Internal, 2. External, 3. Expedited, 4. Fair Hearing.** Grievance script was updated. All rights pertaining to a grievance are fully outlined and shared at the time of the grievance call. Script includes the correct timeframe for sending the acknowledgment notice (3 business days). Script includes requirement to offer translation services when it is identified the member speaks a language other than English, both for the initial call and subsequent discussions and correspondence. Attestation that member rights were reviewed with the caller was added to Customer Contact Form. *(copy of updated Customer Contact Form is attached above- reference Standard 68)*
		Date(s) of follow-up action taken through 6/30/20	**Standard 71, Substandard 3: 100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established timelines. The required letter templates are utilized 100% of the time.** Grievance-specific training was developed and held on 5/9/18. Curriculum included review of possible outcomes (upheld, overturned, partially

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			overturned) and requirement to use decision template from Appendix H of the PS&R that corresponds with each potential outcome. Curriculum emphasized the need for staff recording grievances to promptly submit grievance requests to Complaint and Grievance team to ensure compliance with correspondence timeframes. *(copy of PowerPoint Training is attached above-reference Standard 60)* Grievance-specific training incorporating the changes from Appendix H and the updated complaint workflow will be developed and held prior to 9/1/18 expected compliance. Training date was 8/22/18. *(copy of PowerPoint Training is attached above-reference Standard 60)* In 2019, the annual Grievances Refresher Training was held on 7/24/19. *(copy of PowerPoint Training is attached above-reference Standard 60)* Magellan will document in the grievance record if there are extenuating circumstances resulting in delayed correspondence. The Grievance Workflow was updated.
		Date(s) of future action planned-8/12/20	In 2020, the annual Grievances Refresher Training was held on 8/12/20. *(copy of PowerPoint Training is attached above-reference Standard 60)*
		Date(s) of future action planned-Ongoing	Grievance Training is conducted annually for all Magellan clinical and medical staff as well as County staff and other panel members.
		Date(s) of follow-up action taken through 6/30/20	**Standard 71, Substandard 4: Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed**

Reference Number	Opportunity for Improvement	Date(s) of Follow-up Action(s) Taken/Planned	MCO Response
Review of compliance with standards conducted by the Commonwealth in reporting year 2016, 2017, and 2018 found MBH to be partially compliant with all three Subparts and non-compliant within one Subpart associated with Structure and Operations Standards.		Date(s) of follow-up action(s) taken through 6/30/20/Ongoing/None	Address within each subpart accordingly.
		Date(s) of future action(s) planned/None	Address within each subpart accordingly.
			and a specific explanation and reason for the decision including the medical necessity criteria utilized. Grievance Templates were updated to align with the language and requirements in Appendix H of the PS&R and NCQA requirements. They were submitted and approved by OMHSAS. Notices will be written in a clear, simple language and include a statement of all services reviewed and a specific explanation and reason for the decision including the MNC used.
		Date(s) of future action planned-9/2/20	The Enhancing Readability: Reducing Jargon in Member Communication Training was held on 9/2/20. *(copy of PowerPoint Training is attached above-reference Standard 72)*

MBH: Magellan Behavioral Health; MCO: managed care organization; RY: reporting year; BH: behavioral health; PS&R: Program Standards and Requirements; PEPS: Program Evaluation Performance Summary; CAP: corrective action plan; QI: quality improvement; QM: quality management; CQI: continuous quality improvement; LGBTQI: lesbian, gay, transgender, queer/questioning, intersex; OMHSAS: Office of Mental Health and Substance Abuse Services; SA: substance abuse.

Root Cause Analysis and Quality Improvement Plan

For PMs that are noted as opportunities for improvement in the EQR Technical Report, BH-MCOs are required to submit:

- a goal statement;
- root cause analysis and analysis findings;
- action plan to address findings;
- implementation dates; and
- a monitoring plan to assure action is effective and to address what will be measured and how often that measurement will occur.

Following several years of underperformance in the key quality indicator areas, OMHSAS determined in 2017 that it was necessary to change the PM remediation process so that BH-MCOs would set goals for the coming year. In 2017, this change meant, among other things, eliminating the requirement to complete root cause analyses (RCAs) and quality improvement plans (QIPs) responding to MY 2015. Instead, BH-MCOs were required to submit member-level files for MY 2016 in the summer of 2017, from which rates were calculated and validated by IPRO. MY 2016 Results of HEDIS Follow-Up After Hospitalization for Mental Illness (7- and 30-day) were then used to determine RCA and QIP assignments.

The change coincided with the coming phase-in of value-based payment (VBP) at the Primary Contractor level in January 2018. Thus, for the first time, RCA and QIP assignments were made at the Contractor level as well as at the BH-MCO level. Contractors receiving assignments completed their RCAs and QIPs in November 2017, while BH-MCOs completed

their RCAs and QIPs by December 31, 2017. In 2018, coinciding with the carve-in of long-term care, OMHSAS directed BH-MCOs to begin focusing their RCA and QIP work on the HEDIS FUH All Ages measure and implemented a new goal-setting logic to spur performance improvement in the measure. Based on the MY 2017 performance, BH-MCOs were required to submit RCAs on the HEDIS FUH All Ages 7- and/or 30-day measure and QIPs to achieve their MY 2019 goals. Primary Contractors that scored below the 75th NCQA Quality Compass percentile were also asked to submit RCAs, with the option of submitting a QIP, either through their BH-MCO submission, or separately. BH-MCOs submitted their RCAs and QIPs on April 1, 2019. Primary Contractors submitted their RCAs and QIPs by April 30, 2019. As a result of this shift to a proactive process, MY 2018 goals for FUH All-Ages were never set.

Instead, in late 2020, MY 2019 results were calculated and compared to the MY 2019 goals to determine RCA and QIP assignments, along with goals, for MY 2021. In MY 2019, MBH scored below the 75th percentile on both the 7- and 30-day measures and, as a result, was required to complete an RCA and QIP response for both measures. **Table 5.2** presents MBH's submission of its RCA and QIP for the FUH All-Ages 7-day measure, and **Table 5.3** presents MBH's submission of its RCA and QIP for the FUH All-Ages 30-day measure. Objects embedded within the tables have been removed as exhibits but are available upon request.

Table 5.2: MBH RCA and CAP for the FUH 7–Day Measure (All Ages)

RCA for MY 2019 Underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?): Magellan examined the 7-Day FUH data by first breaking it down by demographic factors to determine which factors were associated with higher or lower FUH rates. Factors examined included county, age, gender, race, and ethnicity. The data in the State's Tableau database was examined via "head to head" comparisons between populations. Special attention was given to identifying disparities related to race, comparing FUH rates for the White subpopulation with the FUH rates for each non-White race group as well as all non-White race groups combined. Similarly, Magellan examined differences in FUH rates related to ethnicity via the head to head comparison for the Hispanic and non-Hispanic populations. Magellan also sought input on barriers to FUH by re-surveying inpatient providers with a survey similar to that which was administered last year, in order to identify any changes in barriers identified. This provider input was incorporated into the list of barriers/causal factors identified in the previous Root Cause Analysis, then adjustments were made to the list of causal factors accordingly. An Ishikawa "fishbone" diagram was constructed to illustrate the causal factors identified in this current Root Cause Analysis (see document "FUH RCA Fishbone 2021"). Magellan decided to combine a few causal factors into "bundles" of causal factors, because the interventions planned would address the whole bundle and not just each single factor. Each identified causal factor was discussed, and the level of actionability was determined, taking into account Magellan's previous and current interventions, as well as ideas and suggestions about newly identified or newly refined causal factors. Extra attention centered on how to address identified disparities related to race and ethnicity. Please see the attachment "RCA 7-day FUH MY2019" for details and results of this analysis.	***Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:*** Please refer to Magellan's root cause analysis, in this embedded document: In addition, the attached Logic Models illustrate the anticipated effects of Magellan's planned interventions.
List out below the factors you identified in your RCA. Insert more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance and any disparities (as defined above) in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***

RCA for MY 2019 Underperformance	
People (1) ***Co-Occurring Disorders*** • ***Substance use relapse*** • ***SUD not sufficiently addressed***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Because this factor can independently impact FUH rates and can also interact with other factors to impact FUH rates, the causal role is significant. The causal weight for this factor is critical, considering the quantitative (FUH rates for people with co-occurring disorders) and qualitative findings (member and provider opinions).
	Current and expected actionability: High Magellan sees multiple opportunities to continue and enhance existing interventions targeting this factor.
People (2) ***Member chooses to not pursue treatment*** • ***Past negative experiences with treatment*** • ***Believe they do not need treatment (at precontemplation stage)***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal role of this factor can interact with other factors to contribute to lower FUH rates. The causal weight is important, because if someone is not far enough along in the stages of change, or if they have minimal insight about their illness then, in their view, they do not need treatment. Also, past negative experiences with treatment, even poor customer service from providers, can cause trauma, and result in avoidance of similar situations in the future.
	Current and expected actionability: Moderate Magellan views this as an area of continuing opportunity, to address both the member's experience with outpatient treatment, and providers' ability to intervene with members who are in the precontemplation stage. Magellan can increase monitoring of outpatient "customer service" practices and provide recommendations for improvement to providers. Magellan can also provide training/guidance on working with members who are at precontemplation, both in a standalone training and in routine discussions with providers.
People (3) ***Member-specific demographic factors*** • ***Member-specific Social Determinants of Health (SDoH) factors that present barriers to FUH***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Factors related to a member demographics,

RCA for MY 2019 Underperformance	
• ***Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who identify as Hispanic have higher FUH rates than non-Hispanic members, and members who are Black/ African American show lower FUH rates than members who identify as white).***	including socioeconomic status, interact with other factors to have an unknown causal role in low follow-up rates. For example, a person's race per se may not directly affect the person's ability and willingness to attend follow-up care, but SDoH factors related to socioeconomic status, which can impact some races more than others, can result in a disparate impact on follow-up. In addition to differences in actual barriers, there may also be variation in the degree that people of different sub-groups feel "welcome" in treatment, perhaps due to past experiences with discrimination or related to a need for improvement in provider cultural competency. The true causal role is unknown.
	Current and expected actionability: Moderate, but indirect While Magellan cannot directly mitigate or solve disparities that are related to race, ethnicity, socioeconomic status, and SDoH, Magellan can encourage that such factors are addressed in all discharge planning discussions, so that individualized planning can occur to address strengths and barriers that are affecting the individual member.
Providers (1) ***Inadequate Discharge Planning*** • ***Not enough member input into discharge plan*** • ***Appointment made at a time member can't attend (too early, conflicts with work/school)*** • ***No clear plan for obtaining medications*** • ***SDoH barriers not identified and addressed sufficiently in discharge planning process*** • ***Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor in general, as well as the examples in the bullet points, has a significant causal role in lower FUH rates. The causal weight of this factor is critical, as inadequate discharge planning, especially when discharge plans do not address all individual barriers to follow-up care, is likely to result in lower FUH rates.
	Current and expected actionability: High Magellan views this as a critical area of continuing opportunity for action. Magellan's existing interventions focused on this factor can be further enhanced by "raising the bar" in our expectations of inpatient providers, as well as on Magellan's own care management team, to continue to incorporate Project Re-Engineered Discharge (RED) informed discharge planning components, to ensure full member input into discharge planning, to address or plan for all SDoH barriers that are affecting the individual, and to consider all cultural factors that might be associated with

RCA for MY 2019 Underperformance	
	higher or lower follow-up rates. Magellan considers race, ethnicity, and language as cultural considerations, but also individual factors like religion, and LGBTQIA status.
Providers (2) ***"The Philadelphia Factor"*** • ***Philadelphia-based hospitals are showing lower FUH rates than non-Philadelphia located hospitals*** • ***Philadelphia hospital staff are unfamiliar with behavioral health resources in Magellan members' home counties*** • ***Philadelphia hospitals appear may benefit from additional guidance about best practices in discharge planning*** • ***When a member is homeless, Philadelphia hospitals refer them to a Philadelphia shelter (may be the only option temporarily) and a nearby behavioral health provider in Philadelphia***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Recent examination of FUH data by hospital location and discussion with Magellan's Clinical team has revealed that "the Philadelphia Factor" may have an important role in FUH rates. It was concluded that being discharged from a hospital in Philadelphia, as opposed to elsewhere, is associated with lower FUH rates.
	Current and expected actionability: Moderate Magellan sees opportunities to enhance discharge planning contacts with Philadelphia-based hospitals in a way that will better identify resources and barriers to follow-up in the member's home county, as well as special planning for members who are temporarily homeless and must be temporarily placed in Philadelphia.

RCA for MY 2019 Underperformance	
Providers (3) ***Outpatient provider availability*** • ***Lack of psychiatrist time overall*** • ***Providers not offering openings within seven days, especially in Cambria County***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor can both directly affect FUH rates, as well as indirectly affect them, by combining with other factors. The shortage of psychiatrists and psychiatrist time was previously identified as somewhat important in the previous versions of this RCA. But when combined with other accessibility issues, like a lack of timely response to consumers and referral sources, or the organization's hours of operation, the causal weight is increased. In Cambria County in particular, the issue with Outpatient providers not offering appointments within 7 days has a critical causal role in lower 7-day FUH rates.
	Current and expected actionability: Moderate Magellan will continue to bring explore expansion opportunities to bring new providers into the network, and encourage providers to increase prescriber availability (perhaps by using telehealth alternatives). Magellan can provide more support to inpatient providers in obtaining outpatient appointments within seven days in Cambria County. During concurrent reviews, additional focus can be given to identifying an outpatient follow-up provider and setting up the appointment earlier in the member's stay, rather than waiting until the final days of the hospital stay.
Policies / Procedures (1) ***Inadequate identification of members at higher risk of not attending follow-up care***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor interacts with other factors to contribute to lower FUH rates. The causal weight of this factor is important. It was also noted that Care Managers and providers need to know what to do once they have identified a member as being at higher risk of not attending follow-up.
	Current and expected actionability: Moderate Magellan attempted to address this last year by creating a tool based on internal and external data, to help Care Managers and providers identify who may be at higher risk

<table>
<tr><th colspan="2">RCA for MY 2019 Underperformance</th></tr>
<tr><td></td><td>of not attending follow-up. There is an opportunity to increase the use of this tool, and improve what is done, once a member is identified as being at higher risk. Magellan, one county contractor, and our largest-volume inpatient provider are collaborating on facilitating linkage to peer support services for these members. If this has a favorable impact with this large provider, the practice can be expanded.</td></tr>
<tr><td rowspan="2">Policies / Procedures (2)
Open Access/Walk-In Intakes
• Some outpatient providers will only offer open-access
• Some outpatient providers will only offer intake appointments in the very early morning.</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): The causal role of only offering walk-in intakes to members coming out of hospitals is somewhat important in terms of FUH rates because thought it is not a high-volume issue, it is particularly problematic for the members who experience it. Magellan has given increased attention to this matter in the 2020 and subsequently, has seen improvement in decreasing utilization of open-access for aftercare follow up appointments. This is evidenced by a decrease in reports of outpatient providers only offering walk-in intakes to people coming out of 24-hour care. However, Magellan is also seeing some outpatient providers offer only early-morning intake appointments for people coming out of hospitals. The causal weight of this may be somewhat important, because it may not be a high-volume issue, but it presents a challenge to members coming out of a hospital who may also be facing transportation barriers or adjusting too new medications.</td></tr>
<tr><td>Current and expected actionability: High
Magellan still views this as an actionable issue, and has planned multiple ways to enhance how this issue is identified, tracked, and acted upon. The new Assess-Shape-Collaborate (ASC) tracking and intervention process for provider improvement opportunities may be the best way to enhance the actionability of this factor.</td></tr>
<tr><td>Policies/Procedures (3)
Outpatient Provider Responsiveness
• Lack of timely response to calls/ referrals from inpatient providers
• Lack of timely response to calls from members</td><td>Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown): The causal role of lack of provider responsiveness is assessed to be critical.</td></tr>
</table>

RCA for MY 2019 Underperformance	
• ***Lack of afternoon, evening and weekend appointments for intake***	Members and hospitals continue to report not being able to reach outpatient providers by phone, and leaving messages but not getting return calls. Magellan initiated a multi-year customer service assessment with the largest outpatient providers in 2020, and found that almost 44% of messages left did not result in a return call. The issue with a limited late day, evening, and weekend intake appointments has an important causal role, but the pandemic-related shutdowns and safety measures have interrupted any effort to address this.
	Current and expected actionability: The actionability for addressing provider customer service and answering telephones is high. The actionability for hours of operation expanding to evening and weekend hours is moderate. Magellan plans to continue and enhance the customer service assessment effort, with aggregate reports, and individual provider reports. This will include setting clear expectations around answering calls and returning calls. Magellan can continue to monitor instances of unmet needs for late day, evening, and weekend intakes, and plan interventions when the pandemic related limitations have lifted.
Provisions (1) ***Lack of Transportation***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal role of this factor is important, and it can directly contribute to lower FUH rates. This SDoH barrier was identified by both members and providers as being significant. The causal weight of this factor was recognized in the earlier versions of this RCA as significant/important, and this continues.
	Current and expected actionability: Low While Magellan cannot directly impact transportation challenges, it can indirectly make an impact on this barrier. Although the actionability is low, it is possible to assist inpatient providers with information on transportation services which can help them to make necessary referrals earlier in the hospital stay. A resource tool on Medical Assistance Transportation Program (MATP) was created last year, shared with providers

RCA for MY 2019 Underperformance	
	and posted to Magellan's website, but the provider survey revealed that providers were still largely unfamiliar with it. Magellan sees opportunities to enhance the dissemination and use of this tool, and provide additional education to inpatient providers about helping members access MATP. This causal factor may have low actionability, but it is so significant that even modest interventions must be attempted.
Provisions (2) ***Member lack of technology to make use of telehealth***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The use of telehealth has increased in the past year due to the pandemic shutdowns. Input from inpatient providers and from external consumer surveys has revealed that although telehealth has improved access for many, it presents barriers to some members, particularly those who do not have the technology/hardware, internet access, or level of comfort to effectively make use of telehealth. The causal role of this is important to somewhat important, because though the barriers are not experienced by the majority of members, they are experienced by those most in need (people with SPMI, people with more severe SDoH barriers).
	Current and expected actionability: Moderate, but largely indirect Magellan supports opportunities to provide guidance to providers about the use of telehealth, including assessing member ability to use telehealth and their comfort level as an alternative mode of service delivery. Magellan can also encourage providers to offer telehealth as an option, but to offer the option of in-person services to those who request this, while implementing safety measures.

Quality Improvement Plan for CY 2021			
Rate Goal for 2021 (State the 2021 rate goal from your MY2019 FUH Goal Report here): 39.18%			
The factors above can be thought of as barriers to improvement. For each barrier identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2020 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with Primary Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.			
Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
Co-Occurring Disorders • ***Substance use relapse*** • ***SUD not sufficiently addressed***	Co-Occurring Competence Effort: Internal training and mentoring for Care Managers in best practices for managing cases involving co-occurring disorders. Continue to use Magellan-created tool for identifying who may be at higher risk for not attending follow-up care.	February 2021, Quarterly March 2020, Ongoing	Will monitor: --Frequency of trainings and mentoring sessions --Attendance in trainings and mentoring sessions --Measures of "co-occurring competence" among Care Managers will be made via pre-test and post-test after the training series is complete. Will keep tool available on Magellan of PA website, and for use by CMs and providers. Will review items on the tool routinely and update it if there are any significant new findings to include.

Barrier	***Action***	***Implementation Date***	***Monitoring Plan***
Member chooses to not pursue treatment • ***Past negative experiences with treatment*** • ***Believe they do not need treatment (at Precontemplation stage)***	Continue front-end customer service assessments of OP providers, and identify areas for improvement Track instances of poor customer service in ASC system (under access barriers) Provide training to providers in intervening with individuals who are at "precontemplation"	Baseline assessment was Q3 2020, now assessing annually. Begin separately looking at customer services related ASC items in Q1 2021. Training in enhanced MI skills with Pre-contemplation planned for April 2021	Conduct annual assessment of outpatient customer service. Prepare general report for all OP providers, and individual reports to individual providers and their respective counties. ASCs are tracked and reported monthly. But will separately examine ASC reports that address examples of poor customer service (complaints about member experience, access barriers, etc) Will track attendance among inpatient providers in this training.
Member specific demographic factors • ***Member-specific SDoH factors that present barriers to FUH*** • ***Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who identify as Hispanic have higher FUH rates than non-Hispanic members, and members who are Black/ African American show lower FUH rates than members who identify as white).***	CBO/CBCM referrals: County contractors have partnered with Magellan and local CBOs on referral process to CBCM when member had SDoH challenges around homelessness or risk of homelessness. Include required discussion of cultural factors that can affect FUH in discharge planning discussions, which much be documented in discharge notes. Include as an item in monthly discharge audits of Project RED components (see below) Much of the disparity race may be related to SDoH factors. See above and below for enhancing how SDoH are addressed in discharge planning	Q1 2021, Quarterly Educate Care Managers March 2021. Add to monthly discharge audits April 2021, Monthly	The Clinical team is developing process documents. The Quality Improvement (QI) team will support Clinical in development of monitoring mechanisms for timely referrals to be made to the CBCM. In monthly discharge audits, calculate separate score on whether cultural factors were discussed and adequately addressed in the monthly discharge audits that currently assess Project RED factors.
Inadequate Discharge Planning • ***Not enough member input***	Continue and enhance *Best Practices in Discharge Planning* initiative: • Continue to educate providers on Project RED informed discharge planning, which	Started 2019 Ongoing, Monthly	This effort is discussed in

Barrier	***Action***	***Implementation Date***	***Monitoring Plan***
into discharge plan • ***Appointment made at a time member can't attend*** • ***No clear plan for obtaining medications*** • ***SDoH barriers not identified and addressed sufficiently in discharge planning process*** • ***Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process*** ***(Inadequate Discharge Planning, continued)***	includes member collaboration about FUH care, times/ days/locations of FUH appointments, plans for obtaining medications, and which requires that SDoH barriers be identified and addressed (if they cannot be resolved, at least planned for). • Continue to monitor Project RED adherence among Care Managers and hospitals, and continually increase expectations around Project RED informed components with monthly discharge audits. • Add separate scoring on monthly discharge audits for "cultural factors" being discussed and addressed in discharge planning process. • Seek guidance from Project RED developers at Boston University and incorporate into Magellan's discharge planning practices. • Track and report examples of "Inadequate discharge planning" in ASC system. Intervene with providers. • Continue to expand texting initiative by increasing the numbers of members who consent to text reminders, and ensuring that hospitals report discharges in a timely manner so that texts can be sent to members.	Ongoing, Monthly March 2021, Monthly Beginning 2/26/2021 Began 7/2020, Monthly Enhanced data tracking in Q4 2020, Monthly	monthly meetings involving inpatient CM team, QI team, System Transformation, and other Magellan management. Audits of Project RED adherence are conducted monthly and reported to inpatient CM team. Education/support will be provided on at least a monthly basis by QI and more frequently by Clinical Supervisors. Audit scores and trends will continue to be tracked monthly. Calculate separate score on whether cultural factors were discussed and adequately addressed in the monthly discharge audits that assess Project RED factors. Will document and track guidance/advice provided by the Project RED researchers, and document how and when that is put into effect. Track monthly ASC data on inadequate discharge planning, and Provider intervention meetings related to discharge planning expectations. Data on texting initiative (successful texts that went out, reasons why not) is tracked and reported monthly. Identified the 3 barriers to a successful text being sent; addressing all 3 barriers.

Barrier	***Action***	***Implementation Date***	***Monitoring Plan***
			Began tracking FUH rates of members who received texts, and found that texting does have a positive impact on FUH.
"The Philadelphia Factor" • ***Philadelphia hospitals are showing lower FUH rates than non-Philadelphia hospitals*** • ***Philadelphia hospital staff are unfamiliar with behavioral health resources in Magellan members' home counties*** • ***Philadelphia hospitals appear to need additional guidance about best practices in discharge planning*** ***When a member is homeless, Phila hospitals refer them to a Phila shelter (may be the only option temporarily) and a nearby BH provider in Phila***	Additional education for Philadelphia hospitals about Magellan's best practices in discharge planning (informed by Project RED), and include additional resources on locating BH providers in Magellan's six contracted counties to which to make referrals. Magellan will attempt to engage the two Philadelphia acute inpatient hospitalization providers who take most of these members into Magellan's network, in order to have more continuity of care for these individuals, who may temporarily spend time in Philadelphia and have benefit eligibility in another county.	FUH data tracking began Q1 2021. Planning for enhanced provider education in Q2., Quarterly During 2021, Quarterly	Will continue to monitor FUH rates for Philadelphia hospitals as compared with overall FUH rates. Will identify which Philadelphia hospitals are doing better than others. Routine monitoring of adherence to Project RED informed components continues monthly. New providers coming into Network are monitored via the Network Strategy Committee meetings, and in the Implementation/Oversight process.
Outpatient provider availability • ***Lack of psychiatrist time overall*** • ***Providers not offering openings within seven days, especially in Cambria County***	Tracking of instances in which outpatient appointment is not offered within 7 days of discharge, in the Assess-Shape-Collaborate (ASC) reporting system, with extra attention on Cambria County.	Began 7/2020, Monthly	Monthly analysis of ASC reports will include special attention on lack of availability of follow-up appointments within 7 days of discharge in all counties, including Cambria. For Cambria, will examine when this may be the responsibility of the inpatient provider (did not attempt to make the appointment until the last day) or the outpatient

Barrier	***Action***	***Implementation Date***	***Monitoring Plan***
			provider (no appointments available within 7 days) and plan individual interventions with providers.
Inadequate identification of who is at higher risk of not attending follow-up care	Continue to use Magellan-developed tool for identifying who is at higher risk of not attending follow-up care. Recovery Service Navigator (RSN) Engagement Pilot Project with Bucks County and Horsham Clinic: Magellan is collaborating with its largest-volume inpatient provider and one County contractor in a project to encourage connection of Magellan's RSN team to members while still hospitalized. If this intervention is effective, Magellan will use this project to inform practices within the Network.	Started mid-2020, will continue, Quarterly Q2 2021, Quarterly	Will keep tool available on Magellan of PA website, and for use by CMs and providers. Will review items on the tool annually and update it if there are any significant new findings to include. In addition to tracking member journey information, Magellan will conduct a member experience survey to assess member satisfaction with RSN engagement with Bucks members discharging from Horsham Clinic.
Open Access/Walk-In Intakes • ***Some outpatient providers will only offer open-access*** • ***Some outpatient providers will only offer intake appointments in the very early morning.***	Track and report instances of outpatient providers only offering open-access or "walk-in" intakes to members coming out of 24 hour care, in the ASC system. Also, track and report in ASC system instances of over-reliance on early morning intakes, or lack of intake appointments later in the day.	Began July 2020, and continuing	ASCs are tracked and reported monthly. One area of opportunity identified is routinely examining ASC reports that address open-access/ walk-in intakes being the only option offered to people coming out of 24-hour care. Also tracking interventions with providers, including communication from Magellan Account Executive. Will add emphasis in identifying and tracking a tendency of a provider to only offer early morning intake appointments.
Outpatient Provider Responsiveness • ***Lack of timely response to calls/***	Continue front-end customer service assessments of OP providers, and identify areas for improvement Track instances of "access barriers" and other	Began Q3 2020, Annually Began 7/2020,	Will conduct the assessment again in 2021, and issue an overall report as well as provider-specific reports.

Barrier	***Action***	***Implementation Date***	***Monitoring Plan***
referrals from inpatient providers • ***Lack of timely response to calls from members*** • ***Lack of evening and weekend appointments for intake*** •	concerns related to member experience in ASC system	Monthly	ASC analysis and reporting occurs monthly, then the ASC committee makes recommendations about interventions to me made with providers.
Lack of Transportation	Magellan will provide guidance to inpatient providers on how to access MATP in each PA county and encourage them to initiate applications early in the discharge planning process.	Began to distribute guidance materials June 2020	Will increase the frequency of sharing of the MATP resource document and information available on magellanofpa.com
Member lack of technology to make use of telehealth	Assess during discharge planning what kind of technology the member has, and what follow-up provider has and can offer. Does member need a provider that has in-person visits? If member comfortable using telehealth?	Begin Q2 2021, and ongoing	Discharge notes will show whether telehealth needs and resources have been discussed. Discuss adding prompts about telehealth needs/resources to discharge notes

RCA: root cause analysis; FUH: follow-up after hospitalization for mental illness; MCO: managed care organization; SUD: substance use disorder; LGBTQIA: lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/ally; SPMI: serious/severe and persistent mental illness.

Table 5.3: MBH RCA and CAP for the 30-Day Measure (All Ages)

RCA for MY 2019 Underperformance	
Discussion of Analysis (What data and analytic methods were employed to identify and link factors contributing to underperformance in the performance indicator in question?):	***Describe here your overall findings. Please explain the underperformance and any racial (White vs non-White cohorts) and/or ethnic disparities using some kind of model linking causes and effects (logic model of change). The linkages and overall conclusions should be empirically supported whenever possible. Logic Model of Change templates, Causal Loop Diagrams, and similar best (RCA) practices are encouraged:***
Magellan examined the 30-Day FUH data by first breaking it down by demographic factors to determine which factors were associated with higher or lower FUH rates. Factors examined included county, age, gender, race, and ethnicity. The data in the State's Tableau database was examined via "head to head" comparisons between populations. Special attention was given to identifying disparities related to race, comparing FUH rates for the White subpopulation with the FUH rates for each non-White race group as well as all non-White race groups combined. Similarly, Magellan examined differences in FUH rates related to ethnicity via the head to head comparison for the Hispanic and non-Hispanic populations. Magellan also sought input on barriers to FUH by re-surveying inpatient providers with a survey similar to that which was administered last year, in order to identify any changes in barriers identified. This provider input was incorporated into the list of barriers/causal factors identified in the previous Root Cause Analysis, then adjustments were made to the list of causal factors accordingly. An Ishikawa "fishbone" diagram was constructed to illustrate the causal factors identified in this current Root Cause Analysis (see document "FUH RCA Fishbone 2021"). Magellan decided to combine a few causal factors into "bundles" of causal factors, because the interventions planned would address the whole bundle and not just each single factor. Each identified causal factor was discussed, and the level of actionability was determined taking into account Magellan's previous and current interventions, as well as ideas and suggestions about newly identified or newly refined causal factors. Extra attention centered on how to address identified disparities related to race and ethnicity. Please see the attachment "RCA 30-day FUH MY2019" for details and results of this analysis.	Please refer to Magellan's root cause analysis, in this embedded document: In addition, the attached Logic Models illustrate the anticipated effects of Magellan's planned interventions.
List out below the factors you identified in your RCA. Insert more rows as needed (e.g., if there are three provider factors to be addressed, insert another row, and split for the second column, to include the third factor).	***Discuss each factor's role in contributing to underperformance and any disparities(as defined above) in the performance indicator in question. Assess its "causal weight" as well as your MCO's current and expected capacity to address it ("actionability").***

RCA for MY 2019 Underperformance	
People (1) ***Co-Occurring Disorders*** • ***Substance use relapse*** • ***SUD not sufficiently addressed***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Because this factor can independently impact FUH rates and can also interact with other factors to impact FUH rates, the causal role is significant. The causal weight for this factor is critical, considering the quantitative (FUH rates for people with co-occurring disorders) and qualitative findings (member and provider opinions).
	Current and expected actionability: High Magellan sees multiple opportunities to continue and enhance existing interventions targeting this factor.
People (2) ***Member chooses to not pursue treatment*** • ***Past negative experiences with treatment*** • ***Believe they do not need treatment (at precontemplation stage)***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal role of this factor can interact with other factors to contribute to lower FUH rates. The causal weight is important, because if someone is not far enough along in the stages of change, or if they have minimal insight about their illness then, in their view, they do not need treatment. Also, past negative experiences with treatment, even poor customer service from providers, can cause trauma, and result in avoidance of similar situations in the future.
	Current and expected actionability: Moderate Magellan views this as an area of continuing opportunity, to address both the member's experience with outpatient treatment, and providers' ability to intervene with members who are in the precontemplation stage. Magellan can increase monitoring of outpatient "customer service" practices and provide recommendations for improvement to providers. Magellan can also provide training/guidance on working with members who are at precontemplation, both in a standalone training and in routine discussions with providers.
People (3) ***Member specific demographic factors*** • ***Member-specific Social Determinants of Health (SDoH) factors that present barriers to FUH*** • ***Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who identify as Hispanic have higher FUH rates than non-Hispanic members, and members who are Black/ African American show lower FUH rates than members who identify as white).***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Factors related to a member demographics, including socioeconomic status, interact with other factors to have an unknown causal role in low follow-up rates. For example, a person's race per se may not directly affect the person's ability and willingness to attend follow-up care, but SDoH factors related to socioeconomic status, which can impact some races more than others, can result in a disparate impact on follow-up. In addition to differences in actual barriers, there may also be variation in the degree that people of different sub-groups feel "welcome" in treatment, perhaps due to past experiences with discrimination or related to a need for improvement in provider cultural competency. The true causal role is unknown.
	Current and expected actionability: Moderate, but indirect While Magellan cannot directly mitigate or solve disparities that are related to race, ethnicity, socioeconomic status, and SDoH, Magellan can ensure that such factors are addressed in all discharge planning discussions, so that individualized planning can occur to address barriers that are affecting the individual member.

RCA for MY 2019 Underperformance	
Providers (1) ***Inadequate Discharge Planning*** • ***Not enough Member input into discharge plan*** • ***Appointment made at a time Member can't attend (too early, conflicts with work/school)*** • ***No clear plan for obtaining medications*** • ***SDoH barriers not identified and addressed sufficiently in discharge planning process*** • ***Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor in general, as well as the examples in the bullet points, has a significant causal role in lower FUH rates. The causal weight of this factor is critical, as inadequate discharge planning, especially when discharge plans do not address all barriers to follow-up care, is likely to result in lower FUH rates.
	Current and expected actionability: High Magellan views this as a critical area of continuing opportunity for action. Magellan's existing interventions focused on this factor can be further enhanced by "raising the bar" in our expectations of inpatient providers, as well as on Magellan's own care management team, to continue to incorporate Project Re-Engineered Discharge (RED) informed discharge planning components, to ensure full member input into discharge planning, to address or plan for all SDoH barriers that are affecting the individual, and to consider all cultural factors that might be associated with higher or lower follow-up rates. Magellan considers race, ethnicity, and language as cultural considerations, but also individual factors like religion, and LGBTQIA status.
Providers (2) ***"The Philadelphia Factor"*** • ***Philadelphia-based hospitals are showing lower FUH rates than non-Philadelphia located hospitals*** • ***Philadelphia hospital staff are unfamiliar with behavioral health resources in Magellan members' home counties*** • ***Philadelphia hospitals appear may benefit from additional guidance about best practices in discharge planning*** • ***When a member is homeless, Philadelphia hospitals refer them to a Philadelphia shelter (may be the only option temporarily) and a nearby behavioral health provider in Philadelphia***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** Recent examination of FUH data by hospital location and discussion with Magellan's Clinical team has revealed that "the Philadelphia Factor" may have an important role in FUH rates. It was concluded that being discharged from a hospital in Philadelphia, as opposed to elsewhere, has a negative impact on FUH rates.
	Current and expected actionability: Moderate Magellan sees opportunities to enhance discharge planning contacts with Philadelphia-based hospitals in a way that will better identify resources and barriers to follow-up in the member's home county, as well as special planning for members who are temporarily homeless and must be temporarily placed in Philadelphia.
Providers (3) ***Outpatient provider availability*** • ***Lack of psychiatrist time overall*** • ***Providers not offering openings within 30 days***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor can both directly affect FUH rates, as well as indirectly affect them, by combining with other factors. The shortage of psychiatrists and psychiatrist time was previously identified as somewhat important in the previous versions of this RCA. But when combined with other accessibility issues, like a lack of timely response to consumers and referral sources, or the organization's hours of operation, the causal weight is increased.
	Current and expected actionability: Moderate Magellan will continue to bring explore expansion opportunities to bring new providers into the network, and encourage providers to increase prescriber availability (perhaps by using telehealth alternatives). Magellan can provide more support to inpatient providers in obtaining

RCA for MY 2019 Underperformance	
	outpatient appointments promptly after the date of discharge. During concurrent reviews, additional focus can be given to identifying an outpatient follow-up provider and setting up the appointment earlier in the member's stay, rather than waiting until the final days of the hospital stay.
Policies / Procedures (1) ***Inadequate identification of members at higher risk of not attending follow-up care***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** This factor interacts with other factors to contribute to lower FUH rates. The causal weight of this factor is important. It was also noted that Care Managers and providers need to know what to do next, when they have identified a member as being at higher risk of not attending follow-up.
	Current and expected actionability: Moderate Magellan attempted to address this last year by creating a tool based on internal and external data, to help Care Managers and providers identify who may be at higher risk of not attending follow-up. There is an opportunity to increase the use of this tool, and improve what is done, once a member is identified as being at higher risk. Magellan, one county contractor, and our largest-volume inpatient provider are collaborating on facilitating linkage to peer support services for these members. If this has a favorable impact with this large provider, the practice can be expanded.
Policies / Procedures (2) ***Open Access/Walk-In Intakes*** • ***Some outpatient providers will only offer open-access*** • ***Some outpatient providers will only offer intake appointments in the very early morning.***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal role of only offering walk-in intakes to members coming out of hospitals is somewhat important in terms of FUH rates because thought it is not a high-volume issue, it is particularly problematic for the members who experience it. Magellan has given increased attention to this matter in the 2020 and subsequently, has seen improvement in decreasing utilization of open-access for aftercare follow up appointments. This is evidenced by a decrease in reports of outpatient providers only offering walk-in intakes to people coming out of 24-hour care. However, Magellan is also seeing some outpatient providers offer only early-morning intake appointments for people coming out of hospitals. The causal weight of this may be somewhat important, because it may not be a high-volume issue, but it presents a challenge to members coming out of a hospital who may also be facing transportation barriers or adjusting too new medications.
	Current and expected actionability: High Magellan still views this as an actionable issue, and has planned multiple ways to enhance how this issue is identified, tracked, and acted upon. The new Assess-Shape-Collaborate (ASC) tracking process for provider improvement opportunities may be the best way to enhance the actionability of this factor.
Policies/Procedures (3) ***Outpatient Provider Responsiveness*** • ***Lack of timely response to calls/ referrals from inpatient providers*** • ***Lack of timely response to calls from***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal role of lack of provider responsiveness is assessed to be critical. Members and hospitals continue to report not being able to reach outpatient providers by phone, and leaving messages but not getting

RCA for MY 2019 Underperformance	
members • ***Lack of afternoon, evening and weekend appointments for intake***	return calls. Magellan initiated a multi-year customer service assessment with the largest outpatient providers in 2020, and found that almost 44% of messages left did not result in a return call. The issue with a limited late day, evening, and weekend intake appointments has an important causal role, but the pandemic-related shutdowns and safety measures have interrupted any effort to address this.
	Current and expected actionability: The actionability for addressing provider customer service and answering telephones is high. The actionability for hours of operation expanding to evening and weekend hours is moderate. Magellan plans to continue and enhance the customer service assessment effort, with aggregate reports, and individual provider reports. This will include setting clear expectations around answering calls and returning calls. Magellan can continue to monitor instances of unmet needs for late day, evening, and weekend intakes, and plan interventions when the pandemic related limitations have lifted.
Provisions (1) ***Lack of Transportation***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The causal role of this factor is important, and it can directly contribute to lower FUH rates. This SDoH barrier was identified by both members and providers as being significant. The causal weight of this factor was recognized in the earlier versions of this RCA as significant/important, and this continues.
	Current and expected actionability: Low While Magellan cannot directly impact transportation challenges, it can indirectly make an impact on this barrier. Although the actionability is low, it is possible to assist inpatient providers with information on transportation services which can help them to make necessary referrals earlier in the hospital stay. A resource tool on Medical Assistance Transportation Program (MATP) was created last year, shared with providers and posted to Magellan's website, but the provider survey revealed that providers were still largely unfamiliar with it. Magellan sees opportunities to enhance the dissemination and use of this tool, and provide additional education to inpatient providers about helping members access MATP. This causal factor may have low actionability, but it is so significant that even modest interventions must be attempted.
Provisions (2) ***Member lack of technology to make use of telehealth***	***Causal Role (relationship to other factors and to the overall performance indicator) and Weight (Critical, Important, Somewhat Important, Not Very Important, Unknown):*** The use of telehealth has increased in the past year due to the pandemic shutdowns. Input from inpatient providers and from external consumer surveys has revealed that although telehealth has improved access for many, it presents barriers to some members, particularly those who do not have the technology/hardware, internet access, or level of comfort to effectively make use of telehealth. The causal role of this is important to somewhat important, because though the barriers are not experienced by the majority of members, they are experienced by those most in need (people with SPMI, people with more severe SDoH barriers).

RCA for MY 2019 Underperformance	
	Current and expected actionability: Moderate, but largely indirect Magellan supports opportunities to provide guidance to providers about the use of telehealth, including assessing member ability to use telehealth and their comfort level as an alternative mode of service delivery. Magellan can also encourage providers to offer telehealth as an option, but to offer the option of in-person services to those who request this, while implementing safety measures.

Quality Improvement Plan for CY 2021			
Rate Goal for 2021 (State the 2021 rate goal from your MY2019 FUH Goal Report here): 62.63%			
The factors above can be thought of as barriers to improvement. For each barrier identified on the previous page (except those deemed Not Very Important), indicate the actions planned and/or actions taken since December 2020 to address that barrier. Actions should describe the Why (link back to factor discussion), What, How, Who, and When of the action. To the extent possible, actions should fit into your overall logic model of change (taking into account the interaction of factors) and align with Primary Contractor QIPs. Then, indicate implementation date of the action, along with a plan for how your MCO will monitor that the action is being faithfully implemented. For factors of Unknown weight, please describe your plan to test for and monitor its importance with respect to the performance indicator.			
Barrier	***Action*** *Include those planned as well as already implemented.*	***Implementation Date*** *Indicate start date (month, year) duration and frequency (e.g., Ongoing, Quarterly)*	***Monitoring Plan*** *How will you know if this action is taking place? How will you know the action is having its intended effect? What will you measure and how often? Include what measurements will be used, as applicable.*
Co-Occurring Disorders • ***Substance use relapse*** • ***SUD not sufficiently addressed***	Co-Occurring Competence Effort: Internal training and mentoring for Care Managers in best practices for managing cases involving co-occurring disorders. Continue to use Magellan-created tool for identifying who may be at higher risk for not attending follow-up care.	February 2021, Quarterly March 2020, Ongoing	Will monitor: --Frequency of trainings and mentoring sessions --Attendance in trainings and mentoring sessions --Measures of "co-occurring competence" among Care Managers will be made via pre-test and post-test after the training series is complete. Will keep tool available on Magellan of PA website, and for use by CMs and providers. Will review items on the tool routinely and update it if there are any significant new findings to include.

Barrier	Action	Implementation Date	Monitoring Plan
Member chooses to not pursue treatment • ***Past negative experiences with treatment*** • ***Believe they do not need treatment (at Precontemplation stage)***	Continue front-end customer service assessments of OP providers, and identify areas for improvement Track instances of poor customer service in ASC system (under access barriers) Provide training to providers in intervening with individuals who are at "precontemplation"	Baseline assessment was Q3 2020, now assessing annually. Begin separately looking at customer services related ASC items in Q1 2021. Training in enhanced MI skills with Pre-contemplation planned for April 2021	Conduct annual assessment of outpatient customer service. Prepare general report for all OP providers, and individual reports to individual providers and their respective counties. ASCs are tracked and reported monthly. But will separately examine ASC reports that address examples of poor customer service (complaints about member experience, access barriers, etc) Will track attendance among inpatient providers in this training.
Member specific demographic factors • ***Member-specific SDoH factors that present barriers to FUH*** • ***Member-specific cultural factors that may be associated with higher or lower FUH (for example, members who identify as Hispanic have higher FUH rates than non-Hispanic members, and members who are Black/ African American show lower FUH rates than members who identify as white).***	CBO/CBCM referrals: County contractors have partnered with Magellan and local CBOs on referral process to CBCM when member had SDoH challenges around homelessness or risk of homelessness. Include required discussion of cultural factors that can affect FUH in discharge planning discussions, which much be documented in discharge notes. Include as an item in monthly discharge audits of Project RED components (see below) Much of the disparity race may be related to SDoH factors. See above and below for enhancing how SDoH are addressed in discharge planning	Q1 2021, Quarterly Educate Care Managers March 2021. Add to monthly discharge audits April 2021, Monthly	The Clinical team is developing process documents. The Quality Improvement (QI) team will support Clinical in development of monitoring mechanisms for timely referrals to be made to the CBCM. In monthly discharge audits, calculate separate score on whether cultural factors were discussed and adequately addressed in the monthly discharge audits that currently assess Project RED factors.
Inadequate Discharge Planning • ***Not enough member input into discharge plan*** • ***Appointment made at a time***	Continue and enhance *Best Practices in Discharge Planning* initiative: • Continue to educate providers on Project RED informed discharge planning, which includes member collaboration about FUH care, times/ days/locations of FUH	Started 2019 Ongoing, Monthly	This effort is discussed in monthly meetings involving inpatient CM team, QI team, System Transformation, and other Magellan management.

Barrier	Action	Implementation Date	Monitoring Plan
member can't attend • ***No clear plan for obtaining medications*** • ***SDoH barriers not identified and addressed sufficiently in discharge planning process*** • ***Lack of attention to barriers related to culture (race, ethnicity, language, LGBTQIA status, etc., in discharge planning process*** ***(Inadequate Discharge Planning, continued)***	appointments, plans for obtaining medications, and which requires that SDoH barriers be identified and addressed (if they cannot be resolved, at least planned for). • Continue to monitor Project RED adherence among Care Managers and hospitals, and continually increase expectations around Project RED informed components with monthly discharge audits. • Add separate scoring on monthly discharge audits for "cultural factors" being discussed and addressed in discharge planning process. • Seek guidance from Project RED developers at Boston University and incorporate into Magellan's discharge planning practices. • Track and report examples of "Inadequate discharge planning" in ASC system. Intervene with providers. • Continue to expand texting initiative by increasing the numbers of members who consent to text reminders, and ensuring that hospitals report discharges in a timely manner so that texts can be sent to members.	Ongoing, Monthly March 2021, Monthly Beginning 2/26/2021 Began 7/2020, Monthly Enhanced data tracking in Q4 2020, Monthly	Audits of Project RED adherence are conducted monthly and reported to inpatient CM team. Education/support will be provided on at least a monthly basis by QI and more frequently by Clinical Supervisors. Audit scores and trends will continue to be tracked monthly. Calculate separate score on whether cultural factors were discussed and adequately addressed in the monthly discharge audits that assess Project RED factors. Will document and track guidance/advice provided by the Project RED researchers, and document how and when that is put into effect. Track monthly ASC data on inadequate discharge planning, and Provider intervention meetings related to discharge planning expectations. Data on texting initiative (successful texts that went out, reasons why not) is tracked and reported monthly. Identified the 3 barriers to a successful text being sent; addressing all 3 barriers. Began tracking FUH rates of members who received texts, and found that texting does have a positive impact on FUH.
"The Philadelphia Factor" • ***Philadelphia hospitals are showing lower FUH rates than non-Philadelphia hospitals*** • ***Philadelphia hospital staff are unfamiliar with behavioral health resources in***	Additional education for Philadelphia hospitals about Magellan's best practices in discharge planning (informed by Project RED), and include additional resources on locating BH providers in Magellan's six contracted counties to which to make referrals. Magellan will attempt to engage the two Philadelphia acute inpatient hospitalization providers who take	FUH data tracking began Q1 2021. Planning for enhanced provider education in Q2., Quarterly During 2021, Quarterly	Will continue to monitor FUH rates for Philadelphia hospitals as compared with overall FUH rates. Will identify which Philadelphia hospitals are doing better than others. Routine monitoring of adherence to Project RED informed components continues monthly. New providers coming into Network are monitored via the Network Strategy

Barrier	Action	Implementation Date	Monitoring Plan
Magellan members' home counties • ***Philadelphia hospitals appear to need additional guidance about best practices in discharge planning When a member is homeless, Phila hospitals refer them to a Phila shelter (may be the only option temporarily) and a nearby BH provider in Phila***	most of these members into Magellan's network, in order to have more continuity of care for these individuals, who may temporarily spend time in Philadelphia and have benefit eligibility in another county.		Committee meetings, and in the Implementation/Oversight process.
Outpatient provider availability • ***Lack of psychiatrist time overall*** • ***Providers not offering openings within 30 days***	Tracking of instances in which outpatient appointment is not offered within 30 days of discharge, in the Assess-Shape-Collaborate (ASC) reporting system.	Began 7/2020, Monthly	Monthly analysis of ASC reports will include special attention on lack of availability of follow-up appointments within 30 days of discharge in all counties. Will examine when this may be the responsibility of the inpatient provider (did not attempt to make the appointment until the last day) or the outpatient provider (no appointments available within 30 days) and plan individual interventions with providers.
Inadequate identification of who is at higher risk of not attending follow-up care	Continue to use Magellan-developed tool for identifying who is at higher risk of not attending follow-up care. Recovery Service Navigator (RSN) Engagement Pilot Project with Bucks County and Horsham Clinic: Magellan is collaborating with its largest-volume inpatient provider and one County contractor in a project to encourage connection of Magellan's RSN team to members while still hospitalized. If this intervention is effective, Magellan will use this project to inform practices within the Network.	Started mid-2020, will continue, Quarterly Q2 2021, Quarterly	Will keep tool available on Magellan of PA website, and for use by CMs and providers. Will review items on the tool annually and update it if there are any significant new findings to include. In addition to tracking member journey information, Magellan will conduct a member experience survey to assess member satisfaction with RSN engagement with Bucks members discharging from Horsham Clinic.

Barrier	Action	Implementation Date	Monitoring Plan
Open Access/Walk-In Intakes • ***Some outpatient providers will only offer open-access*** • ***Some outpatient providers will only offer intake appointments in the very early morning.***	Track and report instances of outpatient providers only offering open-access or "walk-in" intakes to members coming out of 24 hour care, in the ASC system. Also, track and report in ASC system instances of over-reliance on early morning intakes, or lack of intake appointments later in the day.	Began July 2020, and continuing	ASCs are tracked and reported monthly. One area of opportunity identified is routinely examining ASC reports that address open-access/ walk-in intakes being the only option offered to people coming out of 24-hour care. Also tracking interventions with providers, including communication from Magellan Account Executive. Will add emphasis in identifying and tracking a tendency of a provider to only offer early morning intake appointments.
Outpatient Provider Responsiveness • ***Lack of timely response to calls/ referrals from inpatient providers*** • ***Lack of timely response to calls from members*** • ***Lack of evening and weekend appointments for intake*** •	Continue front-end customer service assessments of OP providers, and identify areas for improvement Track instances of "access barriers" and other concerns related to member experience in ASC system	Began Q3 2020, Annually Began 7/2020, Monthly	Will conduct the assessment again in 2021, and issue an overall report as well as provider-specific reports. ASC analysis and reporting occurs monthly, then the ASC committee makes recommendations about interventions to me made with providers.
Lack of Transportation	Magellan will provide guidance to inpatient providers on how to access MATP in each PA county and encourage them to initiate applications early in the discharge planning process.	Began to distribute guidance materials June 2020	Will increase the frequency of sharing of the MATP resource document and information available on magellanofpa.com
Member lack of technology to make use of telehealth	Assess during discharge planning what kind of technology the member has, and what follow-up provider has and can offer. Does member need a provider that has in-person visits? If member comfortable using telehealth?	Begin Q2 2021, and ongoing	Discharge notes will show whether telehealth needs and resources have been discussed. Discuss adding prompts about telehealth needs/resources to discharge notes

MBH: Magellan Behavioral Health; RCA: root cause analysis; CAP: corrective action plan; FUH: follow-up after hospital for mental illness; LGBTQIA: lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual/ally.

VI: 2020 Strengths and Opportunities for Improvement

The section provides an overview of MBH's 2020 (MY 2019) performance in the following areas: structure and operations standards, PIPs (no MY 2019 results to report), and PMs, with identified strengths and opportunities for improvement.

Strengths

- MBH's HEDIS 7- and 30-Day Follow-Up After Hospitalization for Mental Illness MY 2019 rates (QI 1 and QI 2) for all age groups improved from MY 2018. The change was not statistically significant.
- MBH's HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness MY 2019 rate (QI 2) for the 18–64 years age set was significantly higher than the corresponding HC BH statewide rate.
- MBH's PA-specific 7- and 30-Day Follow-Up After Hospitalization for Mental Illness MY 2019 rates (QI A and QI B) improved from MY 2018. The change was not statistically significant.
- MBH's MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate improved from MY 2018. The change was not statistically significant.

Opportunities for Improvement

- Review of compliance with standards conducted by the Commonwealth in RY 2017, RY 2018, and RY 2019 found MBH to be partially compliant with three sections associated with MMC regulations.
  - MBH was partially compliant with 2 out of 9 categories within Compliance with Standards, including Enrollee Rights and Protections. The partially compliant categories are Assurances of Adequate Capacity and Services and Availability of Services.
  - MBH was partially compliant with the eponymous category in Quality Assessment and Performance Improvement Program.
  - MBH was partially compliant with the single category of Grievance and Appeal Systems within Grievance System.

- MBH's MY 2019 HEDIS 7- and 30-Day Follow-Up After Hospitalization for Mental Illness rates (QI 1 and QI 2) for ages 6+ years did not achieve the goal of meeting or exceeding the HEDIS 75th percentile.
- MBH's HEDIS 7- and 30-day Follow-Up After Hospitalization for Mental Illness MY 2019 rates (QI 1 and QI2) for the 6–17 years age set were significantly below the corresponding statewide HC BH average.
- MBH's PA-specific 7-day Follow-Up After Hospitalization for Mental Illness MY 2019 rates (QI A) for the 18–64 years age set was significantly below the corresponding statewide HC BH rates. The 30-day (QI B) rate for the 18–64 age set was also significantly below the corresponding statewide HC BH average.
- MBH's MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate was statistically significantly above (worse than) the statewide HC BH average.
- MBH's MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge rate did not meet the OMHSAS designated performance goal of 10.0%.

Performance Measure Matrices

The PM Matrices provide a comparative look at quality indicators (QIs) included in the EQR evaluation for Quality Performance of the HC BH-MCO. The comparisons are presented in matrices that are color-coded to indicate when the findings for these measures are notable and whether there is cause for action.

Table 6.1 is a three-by-three matrix depicting the horizontal same-year comparison between the BH-MCO's performance and the applicable HC BH (Statewide) rate and the vertical comparison of the BH-MCO's MY 2019 performance to its prior year performance. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly above (▲), below (▼), or no difference (═). However, the qualitative placement of the performance in the matrix depends on the measure. For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA) measure, lower rates reflect better performance.

Table 6.1: BH-MCO Performance Matrix for MY 2019 PA-Specific 7- and 30-Day Follow-Up After Hospitalization and MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge (All Ages)

		BH-MCO Versus HealthChoices Rate Statistical Significance Comparison		
	Trend	**Poorer**	**No difference**	**Better**
BH-MCO Year-to-Year Statistical Significance Comparison	**Improved**	**C**	**B**	**A**
	No Change	**D** **REA[1]**	**C** **FUH QI A** **FUH QI B**	**B**
	Worsened	**F**	**D**	**C**

[1]For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.
Letter Key: A: Performance is notable. BH-MCOs may have internal goals to improve. B: BH-MCOs may identify continued opportunities for improvement. C-F: Recommend BH-MCOs identify continued opportunities for improvement. FUH QI A: PA-Specific 7-Day Follow-Up After Hospitalization for Mental Illness (All Ages); FUH QI B: PA-Specific 30-Day Follow-Up After Hospitalization for Mental Illness (All Ages); REA: Readmission Within 30 Days of Inpatient Psychiatric Discharge.

Table 6.2 quantifies the performance information presented in **Table 6.1**. It compares the BH-MCO's MY 2019 7- and 30-Day Follow-Up After Hospitalization and Readmission Within 30 Days of Inpatient Psychiatric Discharge rates to prior years' rates for the same indicator for measurement years 2015 through 2019. The last column compares the BH-MCO's MY 2019 rates to the corresponding MY 2019 HC BH (Statewide) rates. When comparing a BH-MCO's rate to the benchmark rate for each indicator, the BH-MCO rate can be statistically significantly above (▲), below (▼), or no difference (═).

Table 6.2: MY 2019 PA-Specific 7- and 30-Day Follow-up After Hospitalization and MY 2019 Readmission Within 30 Days of Inpatient Psychiatric Discharge Rates, Compared Year-over-Year and to HC BH Statewide (All Ages)

Quality Performance Measure	MY 2015 Rate	MY 2016 Rate	MY 2017 Rate	MY 2018 Rate	MY 2019 Rate	MY 2019 HC BH (Statewide) Rate
QI A – PA-Specific 7-Day Follow-up After Hospitalization for Mental Illness (Overall)	55.8% ▼	51.5% ▼	47.6% ▼	50.4% ▲	**51.4% ▲**	52.9% ═
QI B – PA-Specific 30-Day Follow-up After Hospitalization for Mental Illness (Overall)	69.9% ▼	65.7% ▼	63.0% ▼	66.2% ▲	**67.7% ▲**	69.5% ═
Readmission Within 30 Days of Inpatient Psychiatric Discharge[1]	15.2% ═	15.9% ═	15.7% ═	16.0% ═	15.3% ═	13.5% ▲

[1]For the Readmission Within 30 Days of Inpatient Psychiatric Discharge (REA), lower rates reflect better performance. Therefore, a year-to-year rate decrease reflects a year-to-year improvement in performance.
PM: performance measure; MY: measurement year; HC: HealthChoices; BH: behavioral health.

Table 6.3 is a four-by-one matrix that represents the BH-MCO's MY 2019 performance as compared to the HEDIS 90th, 75th, 50th, and 25th percentiles for the MY 2019 HEDIS Overall (ages 6+) FUH 7-Day (QI 1) and 30-Day Follow-up (QI 2) After Hospitalization metrics. An RCA and QIP is required for rates that fall below the 75th percentile.

Table 6.3: BH-MCO Performance Matrix for MY 2019 HEDIS FUH 7- and 30-Day Follow-Up After Hospitalization (All Ages)

HealthChoices BH-MCO HEDIS FUH Comparison[1]
Indicators that are greater than or equal to the 90th percentile.
Indicators that are greater than or equal to the 75th percentile, but less than the 90th percentile. (*Root cause analysis and plan of action required for items that fall below the 75th percentile.)*
Indicators that are greater than or equal to the 50th percentile, but less than the 75th percentile. **FUH QI 1** **FUH QI 2**
Indicators that are less than the 50th percentile.

[1]Rates shown are for ages 6 and over.
FUH QI 1: HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness (All Ages); FUH QI 2: HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness (All Ages).

Table 6.4 shows the BH-MCO's MY 2019 performance for HEDIS (FUH) 7- and 30-day Follow-Up After Hospitalization for Mental Illness (All Ages) relative to the corresponding HEDIS MY 2019 NCQA Quality Compass percentiles.

Table 6.4: BH-MCO's MY 2019 FUH Rates Compared to the Corresponding MY 2019 HEDIS 75th Percentiles (All Ages)

Quality Performance Measure	MY 2019		HEDIS MY 2019 Percentile
	Rate[1]	Compliance	
QI 1 – HEDIS 7-Day Follow-Up After Hospitalization for Mental Illness (All Ages)	38.4%	Not met	Above the 50th and below the 75th percentile
QI 2 – HEDIS 30-Day Follow-Up After Hospitalization for Mental Illness (All Ages)	61.4%	Not met	Above the 50th and below the 75th percentile

[1]Rates shown are for ages 6 + years.

BH: behavioral health; MCO: managed care organization; FUH: Follow-Up After Hospitalization for Mental Illness; MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

VII: Summary of Activities

Performance Improvement Projects

- MBH submitted a Final PIP Report in 2019.

Performance Measures

- MBH reported all performance measures and applicable quality indicators in 2019.

Structure and Operations Standards

- MBH was partially compliant on Compliance with Standards, including Enrollee Rights and Protections, Quality Assessment and Performance Improvement Program, and Grievance System. As applicable, compliance review findings from RY 2019, RY 2018, and RY 2017 were used to make the determinations.

Quality Studies

- SAMHSA's CCBHC Demonstration continued in 2019. For any of its member receiving CCBHC services, MBH covered those services under a Prospective Payment System rate.

2019 Opportunities for Improvement MCO Response

- MBH provided a response to the opportunities for improvement issued in 2019.

2020 Strengths and Opportunities for Improvement

- Both strengths and opportunities for improvement were noted for MBH in 2020 (MY 2019). The BH-MCO will be required to prepare a response in 2021 for the noted opportunities for improvement.

References

[1] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf..

[2] National Committee for Quality Assurance (NCQA). (2020). *HEDIS® volume 2: Technical specifications for health plans.* NCQA. https://store.ncqa.org/hedis-2020-volume-2-epub.html.

[3] National Quality Forum (NQF). (2020, August 12). 3400: Use of pharmacotherapy for opioid use disorder (OUD). *Quality positioning system (QPS) measure description display information. http://www.qualityforum.org/QPS/MeasureDetails.aspx?standardID=3400&print=0&entityTypeID=1.*

[4] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[5] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[6] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[7] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[8] Substance Abuse and Mental Health Services Administration. (2019, August 4). *Key substance use and mental health indicators in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Pub. No. PEP19-5068, NSDUH Series H-54). https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.

[9] Pal, S. (2015). The economic burden of mental health care. *US Pharmacist, 40*(11), 20–21. http://bt.e-ditionsbyfry.com/publication/?m=22400&i=280644&p=54.

[10] Carson, N. J., Vesper, A., Chen, C.-N., & Le Cook, B. (2014). Quality of follow-up after hospitalization for mental illness among patients from racial-ethnic minority groups. *Psychiatric Services, 65*(7), 888–896. https://doi.org/10.1176/appi.ps.201300139.

[11] National Committee for Quality Assurance (NCQA). (2007). *The state of health care quality report.* https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/thank-you/.

[12] Carson, N. J., Vesper, A., Chen, C.-N., & Le Cook, B. (2014). Quality of follow-up after hospitalization for mental illness among patients from racial-ethnic minority groups. *Psychiatric Services, 65*(7), 888–896. https://doi.org/10.1176/appi.ps.201300139.

[13] Ride, J., Kasteridis, P., Gutacker, N., Doran, T., Rice, N., Gravelle, H., Kendrick, T., Mason, A., Goddard, M., Siddiqi, N., Gilbody, S., Williams, R., Aylott, L., Dare, C., & Jacobs, R. (2019). Impact of family practice continuity of care on

unplanned hospital use for people with serious mental illness. *Health Services Research,* 54(6), 1316–1325. https://doi.org/10.1111/1475-6773-13211.

[14] Ride, J., Kasteridis, P., Gutacker, N., Doran, T., Rice, N., Gravelle, H., Kendrick, T., Mason, A., Goddard, M., Siddiqi, N., Gilbody, S., Williams, R., Aylott, L., Dare, C., & Jacobs, R. (2019). Impact of family practice continuity of care on unplanned hospital use for people with serious mental illness. *Health Services Research,* 54(6), 1316–1325. https://doi.org/10.1111/1475-6773-13211.

[15] Smith, M. W., Stocks, C., & Santora, P. B. (2015). Hospital readmission rates and emergency department visits for mental health and substance abuse conditions. *Community Mental Health Journal*, *51*(2), 190–197. https://doi.org/10.1007/s10597-014-9784-x.

[16] Mark, T., Tomic, K. S., Kowlessar, N., Chu, B. C., Vandivort-Warren, R., & Smith, S. (2013). Hospital readmission among Medicaid patients with an index hospitalization for mental and/or substance use disorder. *Journal of Behavioral Health Services & Research, 40*(2), 207–221. https://doi.org/10.1007/s11414-013-9323-5.

[17] Mark, T., Tomic, K. S., Kowlessar, N., Chu, B. C., Vandivort-Warren, R., & Smith, S. (2013). Hospital readmission among Medicaid patients with an index hospitalization for mental and/or substance use disorder. *Journal of Behavioral Health Services & Research, 40*(2), 207–221. https://doi.org/10.1007/s11414-013-9323-5.

[18] Smith, M. W., Stocks, C., & Santora, P. B. (2015). Hospital readmission rates and emergency department visits for mental health and substance abuse conditions. *Community Mental Health Journal*, *51*(2), 190–197. https://doi.org/10.1007/s10597-014-9784-x.

[19] U.S. Department of Health & Human Services. (2016). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf.

[20] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[21] Centers for Medicare & Medicaid Services (CMS). (2019, October). *CMS external quality review (EQR) protocols* (OMB Control No. 0938-0786). Department of Health & Human Services. https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf.

[22] Code of Federal Regulations, Title 42: Public Health. (2021, March 17). 42 CFR § 438.358 – Activities related to external quality review. https://www.ecfr.gov/cgi-bin/ECFR?page=browse.

Appendices

Appendix A. Required PEPS Substandards Pertinent to BBA Regulations

Refer to **Table A.1** for Required PEPS Substandards pertinent to BBA Regulations.[23]

Table A.1: Required PEPS Substandards Pertinent to BBA Regulations

BBA Category	PEPS Reference	PEPS Language
Assurances of adequate capacity and services 42 C.F.R. § 438.207	Substandard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access time frames (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service (e.g., all outpatient providers should be listed on the same page or consecutive pages). • Excel or Access database with the following information: Name of Agency (include satellite sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (e.g., adult, child and adolescent); Priority Population; Special Population.
	Substandard 1.2	100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.
	Substandard 1.4	BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).
	Substandard 1.5	BH-MCO has notified the Department of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Substandard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees.
Availability of Services 42 C.F.R § 438.206, 42 C.F.R. § 10(h)	Substandard 1.1	• A complete listing of all contracted and credentialed providers. • Maps to demonstrate 30 minutes (20 miles) urban and 60 minutes (45 miles) rural access time frames (the mileage standard is used by DOH) for each level of care. • Group all providers by type of service (e.g., all outpatient providers should be listed on the same page or consecutive pages). • Excel or Access database with the following information: Name of Agency (include satellite sites); Address of Agency (and satellite sites) with zip codes; Level of Care (e.g., Partial Hospitalization, D&A Outpatient, etc.); Population served (e.g., adult, child and adolescent); Priority Population; Special Population.
	Substandard 1.2	100% of members given choice of two providers at each level of care within 30/60 miles urban/rural met.
	Substandard 1.3	Provider Exception report submitted and approved when choice of two providers is not given.
	Substandard 1.4	BH-MCO has identified and addressed any gaps in provider network (e.g., cultural, special priority, needs pops or specific services).
	Substandard 1.5	BH-MCO has notified the Department of any drop in provider network. • Monitor provider turnover. • Network remains open where needed.
	Substandard 1.6	BH-MCO must require providers to notify BH-MCO when they are at capacity or not accepting any new enrollees.
	Substandard 1.7	Confirm FQHC providers.
	Substandard 23.1	BH-MCO has assessed if 5% requirement is applicable.
	Substandard 23.2	BH-MCO phone answering procedures provide instruction for non-English

BBA Category	PEPS Reference	PEPS Language
		members if 5% requirement is met.
	Substandard 23.3	List of oral interpreters is available for non-English speakers.
	Substandard 23.4	BH-MCO has provided documentation to confirm if Oral Interpretation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Oral Interpretation is identified as the action of listening to something in one language and orally translating into another language.)
	Substandard 23.5	BH-MCO has provided documentation to confirm if Written Translation services were provided for the calendar year being reviewed. The documentation includes the actual number of services, by contract, that were provided. (Written Translation is defined as the replacement of a written text from one language into an equivalent written text in another language.)
	Substandard 24.1	BH-MCO provider application includes information about handicapped accessibility.
	Substandard 24.2	Provider network database contains required information for ADA compliance.
	Substandard 24.3	BH-MCO phone answering uses TTY or PA telecommunication relay services.
	Substandard 24.4	BH-MCO is able to access interpreter services.
	Substandard 24.5	BH-MCO has the ability to accommodate people who are hard of hearing.
	Substandard 24.6	BH-MCO can make alternate formats available upon request.
	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
Confidentiality 42 C.F.R. § 438.224	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Coordination and continuity of care 42 C.F.R. § 438.208	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
Coverage and authorization of services 42 C.F.R. Parts § 438.210(a–e), 42 C.F.R. § 441, Subpart B, and §	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.

BBA Category	PEPS Reference	PEPS Language
438.114	Substandard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).
Health information systems 42 C.F.R. § 438.242	Substandard 120.1	The County/BH-MCO uses the required reference files as evidenced through correct, complete and accurate encounter data.
Practice guidelines 42 C.F.R. § 438.236	Substandard 28.1	Clinical/chart reviews reflect appropriate consistent application of medical necessity criteria and active care management that identify and address quality of care concerns.
	Substandard 28.2	The medical necessity decision made by the BH-MCO Physician/Psychologist Advisor is supported by documentation in the denial record and reflects appropriate application of medical necessity criteria.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
Provider selection 42 C.F.R. § 438.214	Substandard 10.1	100% of credentialed files should contain licensing or certification required by PA law, verification of enrollment in the MA and/or Medicare program with current MA provider agreement, malpractice/liability insurance, disclosure of past or pending lawsuits or litigation, board certification or eligibility BH-MCO on-site review, as applicable.
	Substandard 10.2	100% of decisions made within 180 days of receipt of application.
	Substandard 10.3	Recredentialing incorporates results of provider profiling.
Subcontractual relationships and delegation 42 C.F.R. § 438.230	Substandard 99.1	The BH-MCO reports monitoring results for quality of individualized service plans and treatment planning.
	Substandard 99.2	The BH-MCO reports monitoring results for adverse incidents.
	Substandard 99.3	The BH-MCO reports monitoring results for collaboration and cooperation with member complaints, grievance and appeal procedures, as well as other medical and human services programs.
	Substandard 99.4	The BH-MCO reports monitoring results for administrative compliance.
	Substandard 99.5	The BH-MCO has implemented a provider profiling process which includes performance measures, baseline thresholds and performance goals.
	Substandard 99.6	Provider profiles and individual monitoring results are reviewed with providers.
	Substandard 99.7	Providers are evaluated based on established goals and corrective action taken as necessary.
	Substandard 99.8	The BH-MCO demonstrates that provider profiling results are incorporated into the network management strategy.
Quality assessment and performance	Substandard 91.1	The QM Program Description clearly outlines the BH-MCO QM structure.
	Substandard 91.2	The QM Program Description clearly outlines the BH-MCO QM content.
	Substandard 91.3	The QM Program Description includes the following basic elements:

BBA Category	PEPS Reference	PEPS Language
improvement program 42 C.F.R. § 438.330		Performance improvement projects Collection and submission of performance measurement data Mechanisms to detect underutilization and overutilization of services Emphasis on, but not limited to, high volume/high-risk services and treatment, such as Behavioral Health Rehabilitation Services Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health needs.
	Substandard 91.4	The QM Work Plan includes: Objective Aspect of care/service Scope of activity Frequency Data source Sample size Responsible person Specific, measurable, attainable, realistic and timely performance goals, as applicable.
	Substandard 91.5	The QM Work Plan outlines the specific activities related to coordination and interaction with other entities, including but not limited to, Physical Health MCO's (PH-MCO).
	Substandard 91.6	The QM Work Plan outlines the formalized collaborative efforts (joint studies) to be conducted.
	Substandard 91.7	The QM Work Plan includes the specific monitoring activities conducted to evaluate the effectiveness of the services received by members: Access to services (routine, urgent and emergent), provider network adequacy, and penetration rates Appropriateness of service authorizations and inter-rater reliability Complaint, grievance and appeal processes; denial rates; and upheld and overturned grievance rates Treatment outcomes: readmission rate, follow-up after hospitalization rates, initiation and engagement rates, and consumer satisfaction.
	Substandard 91.8	The QM Work Plan includes a provider profiling process.
	Substandard 91.9	The QM Work Plan includes the specific monitoring activities conducted to evaluate access and availability to services: Telephone access and responsiveness rates Overall utilization patterns and trends including BHRS and other high volume/high risk services.
	Substandard 91.1	The QM Work Plan includes monitoring activities conducted to evaluate the quality and performance of the provider network: Quality of individualized service plans and treatment planning Adverse incidents Collaboration and cooperation with member complaints, grievance, and appeal procedures as well as other medical and human services programs and administrative compliance.
	Substandard 91.11	The QM Work Plan includes a process for determining provider satisfaction with the BH-MCO.
	Substandard 91.12	The QM Work Plan outlines the specific performance improvement projects conducted to evaluate the BH-MCO's performance related to the following: Performance based contracting selected indicator: Mental Health; and, Substance Abuse External Quality Review: Follow up After Mental Health Hospitalization QM Annual Evaluation
	Substandard 91.13	The identified performance improvement projects must include the following: Measurement of performance using objective quality indicators Implementation of system interventions to achieve improvement in quality Evaluation of the effectiveness of the interventions Planning and initiation of activities for increasing or sustaining improvement Timeline for reporting status and results of each project to the Department of Human Services (DHS) Completion of each performance Improvement project in a reasonable time period to allow information on the success of performance improvement projects to produce new information on quality of care each year
	Substandard 91.14	The QM Work Plan outlines other performance improvement activities to be conducted based on the findings of the Annual Evaluation and any Corrective Actions required from previous reviews.

BBA Category	PEPS Reference	PEPS Language
	Substandard 91.15	The Annual Program Evaluation evaluates the impact and effectiveness of the BH-MCO's quality management program. It includes an analysis of the BH-MCO's internal QM processes and initiatives, as outlined in the program description and the work plan.
	Substandard 93.1	The BH-MCO reports monitoring results for access to services (routine, urgent and emergent), provider network adequacy and penetration rates.
	Substandard 93.2	The BH-MCO reports monitoring results for appropriateness of service authorization and inter-rater reliability.
	Substandard 93.3	The BH-MCO reports monitoring results for: authorizations; complaint, grievance and appeal processes; rates of denials; and rates of grievances upheld or overturned.
	Substandard 93.4	The BH-MCO reports monitoring results for treatment outcomes: readmission rates, follow up after hospitalization rates, and consumer satisfaction.
	Substandard 98.1	The BH-MCO reports monitoring results for telephone access standard and responsiveness rates. Standard: Abandonment rate
	Substandard 98.2	The BH-MCO reports monitoring results for overall utilization patterns and trends, including BHRS service utilization and other high volume/high risk services patterns of over- or under-utilization. BH-MCO takes action to correct utilization problems, including patterns of over- and under-utilization.
	Substandard 98.3	The BH-MCO reports monitoring results for coordination with other service agencies and schools.
	Substandard 104.1	The BH-MCO must measure and report its performance using standard measures required by DHS.
	Substandard 104.2	The BH MCO must submit data to DHS, as specified by DHS, that enables the measurement of the BH-MCO's performance. QM program description must outline timeline for submission of QM program description, work plan, annual QM summary/evaluation, and member satisfaction including Consumer Satisfaction Team reports to DHS.
	Substandard 104.3	Performance Improvement Plans status reported within the established time frames.
	Substandard 104.4	The BH-MCO submitted the following within established timeframes: Annual Evaluation QM Program Description QM Work Plan Quarterly PEPS Reports
Grievance and appeal systems 42 C.F.R. § 438 Parts 228, 402, 404, 406, 408, 410, 414, 416, 420, 424	Substandard 68.1	Interview with Complaint Coordinator(s) demonstrate a clear understanding of the Complaint process including how Member rights and Complaint procedures are made known to Members, BH-MCO staff and the provider network. • 1st level • 2nd level • External • Expedited • Fair Hearing
	Substandard 68.2	Interview with the Complaint Manager(s) demonstrates effective oversight of the Complaint process.
	Substandard 68.3	100% of Complaint Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 68.4	Complaint Acknowledgement and Decision letters must be written in clear, simple language that includes each issue identified in the Member's Complaint and a corresponding explanation and reason for the decision(s).
	Substandard 68.4 (RY 2016, 2017)	The complaint case file includes documentation of the steps taken by the BH-MCO to investigate a complaint. All contacts and findings related to the involved parties are documented in the case file.

BBA Category	PEPS Reference	PEPS Language
	Substandard 68.7	Complaint case files include documentation that Member rights and the Complaint process were reviewed with the Member.
	Substandard 68.9	Complaint case files include documentation of any referrals of Complaint issues to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Complaint staff, either by inclusion in the Complaint case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 71.1	Interview with Grievance Coordinator demonstrates a clear understanding of the Grievance process, including how Grievance rights and procedures are made known to Members, BH-MCO staff and the provider network: • Internal • External • Expedited • Fair Hearing
	Substandard 71.2	Interview with the Grievance Manager(s) demonstrates effective oversight of the Grievance process.
	Substandard 71.2	100% of Grievance Acknowledgement and Decision letters reviewed adhere to the established time lines. The required letter templates are utilized 100% of the time.
	Substandard 71.4	Grievance decision letters must be written in clear, simple language that includes a statement of all services reviewed and a specific explanation and reason for the decision including the medical necessity criteria utilized.
	Substandard 71.7	Grievance case files include documentation that Member rights and the Grievance process were reviewed with the Member.
	Substandard 71.9	Grievance case files must include documentation of any referrals to Primary Contractor/BH-MCO committees for further review and follow-up. Evidence of subsequent corrective action and follow-up by the respective Primary Contractor/BH-MCO Committee must be available to the Grievance staff either by inclusion in the Grievance case file or reference in the case file to where the documentation can be obtained for review.
	Substandard 72.1	Denial notices are issued to members according to required timeframes and use the required template language.
	Substandard 72.2	The content of the notices adhere to OMHSAS requirements (e.g., easy to understand and free from medical jargon; contains explanation of member rights and procedures for filing a grievance, requesting a DPW Fair Hearing, and continuation of services; contains name of contact person; contains specific member demographic information; contains specific reason for denial; contains detailed description of requested services, denied services, and any approved services if applicable; contains date denial decision will take effect).

[23] In 2018, five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, an "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020).

Appendix B. OMHSAS-Specific PEPS Substandards

Refer to **Table B.1** for OMHSAS-Specific PEPS Substandards.[24]

Table B.1: OMHSAS-Specific PEPS Substandards

Category	PEPS Reference	PEPS Language
Care Management		
Care Management (CM) Staffing	Substandard 27.7	Other: Significant onsite review findings related to Standard 27.
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	Other: Significant onsite review findings related to Standard 28.
Complaints and Grievances		
Complaints	Substandard 68.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including, but not limited to: the Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
	Substandard 68.1.2	Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints.
	Substandard 68.5	A verbatim transcript and/or recording of the second level Complaint review meeting is maintained to demonstrate appropriate representation, adherence to the Complaint review meeting process, familiarity with the issues being discussed and that the decision was based on input from all panel members.
	Substandard 68.6	Sign-in sheets are included for each Complaint review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
	Substandard 68.6 (RY 2016, 2017)	The second level complaint case file includes documentation that the member was contacted about the second level complaint meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
	Substandard 68.7 (RY 2016, 2017)	Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.
	Substandard 68.8	Complaint case files include Member and provider contacts related to the Complaint case, investigation notes and evidence, Complaint review summary and identification of all review committee participants, including name, affiliation, job title and role.
Grievances	Substandard 71.1.1	Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.
	Substandard 71.1.2	Training rosters and training curriculums identify that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.
	Substandard 71.5	A verbatim transcript and/or recording of the Grievance review meeting is maintained to demonstrate appropriate representation, adherence to the

Category	PEPS Reference	PEPS Language
		Grievance review meeting process, familiarity with the issues being discussed and that input was provided from all panel members.
	Substandard 71.5 (RY 2016, 2017)	The second level grievance case file includes documentation that the member was contacted about the second level grievance meeting, offered a convenient time and place for the meeting, asked about their ability to get to the meeting, and asked if they need any assistive devices.
	Substandard 71.6	Sign-in sheets are included for each Grievance review meeting that document the meeting date and time, each participant's name, affiliation, job title, role in the meeting, signature and acknowledgement of the confidentiality requirement.
	Substandard 71.6 (RY 2016, 2017)	Training rosters identify that all second level panel members have been trained. Include a copy of the training curriculum.
	Substandard 71.8	Grievance case files include Member and provider contacts related to the Grievance case, Grievance review summary and identification of all review committee participants, including name, affiliation, job title and role.
Denials		
Denials	Substandard 72.3	BH-MCO consistently reports denial data/occurrences to OMHSAS on a monthly basis according to Appendix AA requirements.
Executive Management		
County Executive Management	Substandard 78.5	Other: Significant onsite review findings related to Standard 78.
BH-MCO Executive Management	Substandard 86.3	Other: Significant onsite review findings related to Standard 86.
Enrollee Satisfaction		
Consumer/Family Satisfaction	Substandard 108.3	County's/BH-MCO's role of fiduciary (if applicable) is clearly defined, and provides supportive function as defined in the C/FST Contract, as opposed to directing the program.
	Substandard 108.4	The C/FST Director is responsible for: setting program direction consistent with County direction; negotiating contract; prioritizing budget expenditures; recommending survey content and priority; and directing staff to perform high quality surveys.
	Substandard 108.9	Results of surveys by provider and level of care are reflected in BH-MCO provider profiling, and have resulted in provider action to address issues identified.

[24] In 2018, two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance review process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, an "(RY 2016, RY 2017)" is appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020).

Appendix C: Program Evaluation Performance Summary: OMHSAS-Specific Substandards for MBH Counties

OMHSAS-specific substandards are not required to fulfill BBA requirements. In 2018, two Contractor-specific triennial substandards, 68.1.2 and 71.1.2, were added related to OMHSAS-specific provisions for complaints and grievances processes, respectively. Five MCO-specific substandards related to complaints and grievances provisions (four of which covered BBA provisions) were retired and replaced with eight new substandards related to complaints and grievances. Four of the substandards cover BBA provisions and four are OMHSAS-specific. In some cases, triennial substandards entering and exiting the compliance process were assigned identifying numbers in common with existing substandards (e.g., 71.7) or even with one another (68.6). For this report, in order to distinguish substandards, an "(RY 2017, RY 2018)" will be appended to certain substandard numbers to indicate the version being retired when the MCO next comes up for its three-year review (either in 2019 or 2020). In RY 2019, 18 OMHSAS-specific substandards were evaluated for MBH and its Contractors. **Table C.1** provides a count of the OMHSAS-specific substandards applicable in RY 2019, along with the relevant categories.

Table C.1: Tally of OMHSAS-Specific Substandards Reviewed for MBH

	Evaluated PEPS Substandards[1]		PEPS Substandards Under Active Review[2]		
Category (PEPS Standard)	Total	NR	RY 2019	RY 2018	RY 2017
Care Management					
Care Management (CM) Staffing	1	0	1	0	0
Longitudinal Care Management (and Care Management Record Review)	1	0	1	0	0
Complaints and Grievances					
Complaints	5	0	5	0	0
Grievances	5	0	5	0	0
Denials					
Denials	1	0	1	0	0
Executive Management					
County Executive Management	1	0	1	0	0
BH-MCO Executive Management	1	0	1	0	0
Enrollee Satisfaction					
Consumer/Family Satisfaction	3	0	0	0	3
Total	**18**		**15**	**0**	**3**

[1]The total number of OMHSAS-Specific substandards required for the evaluation of HealthChoices Oversight Entity/BH-MCO compliance with OMHSAS standards. Any PEPS Substandards not reviewed indicate substandards that were deemed not applicable to the HealthChoices Oversight Entity/BH-MCO.
[2]The number of OMHSAS-specific sub-standards that came under active review during the cycle specific to the review year.
OMHSAS: Office of Mental Health & Substance Abuse Services; MBH: Magellan Behavioral Health; PEPS: Program Evaluation Performance Summary; NR: Substandards not reviewed; RY: review year.

Format

This document groups the monitoring standards under the subject headings Care Management, Complaints and Grievances, Denials, Executive Management, and Enrollee Satisfaction. The status of each substandard is presented as it appears in the PEPS Review Application (i.e., met, partially met, not met) and/or applicable RAI tools (i.e., complete, pending) submitted by OMHSAS. This format reflects the goal of this supplemental review, which is to assess the County/BH-MCO's compliance with selected ongoing OMHSAS-specific monitoring standards.

Findings

Care Management

The OMHSAS-specific PEPS Substandards relating to Care Management are MCO-specific review standards. MBH and its Primary Contractors were evaluated on 2 of the 2 applicable substandards. Of the 2 substandards, MBH was compliant with both substandards. The status for these substandards is presented in **Table C.2**.

Table C.2: OMHSAS-Specific Requirements Relating to Care Management

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Care Management					
Care Management (CM) Staffing	Substandard 27.7	2019	All MBH Primary Contractors		
Longitudinal Care Management (and Care Management Record Review)	Substandard 28.3	2019	All MBH Primary Contractors		

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; CM: care management; RY: review year.

Complaints and Grievances

The OMHSAS-specific PEPS Substandards relating to second-level complaints and grievances include MCO-specific and County-specific review standards. MBH and its Primary Contractors were evaluated on 10 of the 10 applicable substandards. Of the 10 substandards evaluated, MBH partially met 4 substandards, as indicated in **Table C.3.**

Table C.3: OMHSAS-Specific Requirements Relating to Complaints and Grievances

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Complaints and Grievances					
Complaints	Substandard 68.1.1	2019	Delaware, Lehigh, Montgomery, Northampton	Bucks, Cambria	
	Substandard 68.1.2	2019	Bucks, Cambria, Lehigh, Montgomery, Northampton	Delaware	
	Substandard 68.5	2019	All MBH Primary Contractors		
	Substandard 68.6	2019	All MBH Primary Contractors		
	Substandard 68.8	2019	All MBH Primary Contractors		
Grievances	Substandard 71.1.1	2019	Bucks, Delaware, Lehigh, Montgomery, Northampton	Cambria	
	Substandard 71.1.2	2019	Bucks, Lehigh, Montgomery, Northampton	Cambria, Delaware	
	Substandard 71.5	2019	All MBH Primary Contractors		
	Substandard 71.6	2019	All MBH Primary Contractors		
	Substandard 71.8	2019	All MBH Primary Contractors		

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year.

MBH was partially compliant with Standard 68.1, Substandard 1 (RY 2019), and Substandard 2 (RY 2019)

Standard 68.1: The Primary Contractor is responsible for monitoring the Complaint process for compliance with Appendix H and the Program Evaluation Performance Summary (PEPS).

Substandard 1: Where applicable there is evidence of Primary Contractor oversight and involvement in the Complaint process, including, but not limited to: the Member Handbook, Complaint decisions, written notification letters, investigations, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns

Substandard 2: Training rosters and training curriculums demonstrate that Complaint staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Complaints.

MBH was partially compliant with Standard 71.1, Substandard 1 (RY 2019), and Substandard 2 (RY 2019).

Standard 71.1: The Primary Contractor is responsible for monitoring the Grievance process for compliance with Appendix H and the Program Evaluation Performance Summary (PEPS).

Substandard 1: Where applicable there is evidence of Primary Contractor oversight and involvement in the Grievance process, included but not limited to the Member Handbook, Grievance decisions, written notification letters, scheduling of reviews, staff trainings, adherence of review committees to the requirements in Appendix H and quality of care concerns.

Substandard 2: Training rosters and training curriculums identify that Grievance staff, as appropriate, have been adequately trained on Member rights related to the processes and how to handle and respond to Member Grievances.

Denials

The OMHSAS-specific PEPS Substandard relating to Denials is an MCO-specific review standard. This substandard was added to the PEPS Application during RY 2015. MBH and its Primary Contractors were evaluated for and met the criteria of this substandard. The status for this substandard is presented in **Table C.4**.

Table C.4: OMHSAS-Specific Requirements Relating to Denials

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Denials					
Denials	Substandard 72.3	2019	All MBH Primary Contractors		

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year; MBH: Magellan Behavioral Health.

Executive Management

There are two OMHSAS-specific PEPS substandards relating to Executive Management; the County Executive Management substandard is a County-specific review standard, and the BH-MCO Executive Management substandard is an MCO-specific review substandard. MBH and its Primary Contractors Cambria, Lehigh, and Northampton were evaluated for the County Executive Management and were found fully compliant. MBH and all its Primary Contractors were evaluated on the BH-MCO Executive Management substandard and were compliant. The status for these substandards is presented in **Table C.5**.

Table C.5: OMHSAS-Specific Requirements Relating to Executive Management

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Executive Management					
County Executive Management	Substandard 78.5	2019	Cambria, Lehigh, Northampton		
BH-MCO Executive Management	Substandard 86.3	2019	All MBH Primary Contractors		

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year.

Enrollee Satisfaction

The OMHSAS-specific PEPS Substandards relating to Enrollee Satisfaction are County-specific review standards. All three substandards crosswalked to this category were evaluated for the five MBH counties and were compliant on all three substandards. The status by county for these is presented in **Table C.6**.

Table C.6: OMHSAS-Specific Requirements Relating to Enrollee Satisfaction

Category	PEPS Item	RY	Status by Primary Contractor		
			Met	Partially Met	Not Met
Enrollee Satisfaction					
Consumer/Family Satisfaction	Substandard 108.3	2017	All MBH Primary Contractors		
	Substandard 108.4	2017	All MBH Primary Contractors		
	Substandard 108.9	2017	All MBH Primary Contractors		

OMHSAS: Office of Mental Health & Substance Abuse Services; PEPS: Program Evaluation Performance Summary; RY: review year.